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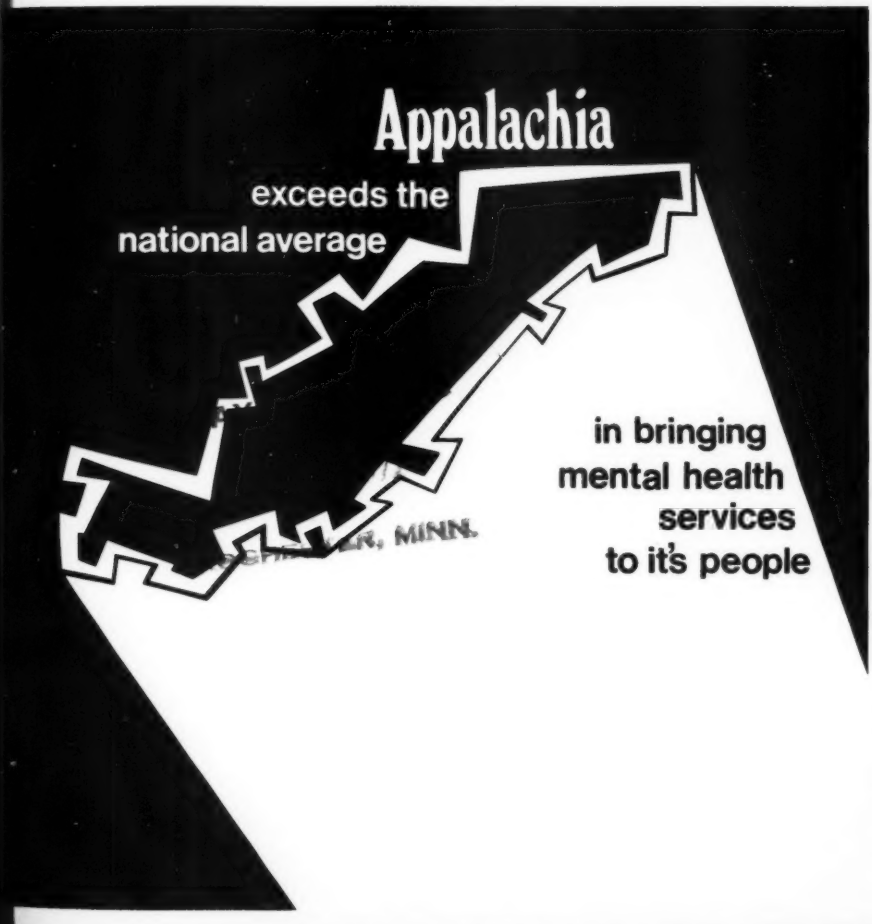

cover story

This issue of the *Digest* contains several condensations of articles on delivery of mental health services. A story about mental health services in Appalachia appears on page 44.

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contents

mental health digest, Vol. 4, No. 8, August 1972

1 Moving Pictures as an Aid in Community Development
by Alexander H. Leighton, Edward A. Mason, Joseph C. Kern, and Frederick A. Leighton
from *Human Organization*

6 Sectorization: The Quiet Revolution in European Mental Health Care
by Martin Gittelman
from the *American Journal of Orthopsychiatry*

11 The Community as a Social System
by Frederick L. Bates and Lloyd Bacon
from *Social Forces*

15 A National View of Transitional Living Programs
by Lucy D. Ozarin
from a speech delivered at the Kansas Conference on Transitional Living Programs

17 Mental Health Planning and Evaluation for the Black and the Poor
by Alyce C. Gullattee
from the *Journal of the National Medical Association*

23 Communication in Community Decisions on the Problems of the Poor
by James E. Grunig
from the *Journal of Communication*

28 A Suggested School Mental Health Program
by Richard S. Abrams, Michael Vanecko, and Irving Abrams
from *The Journal of School Health*

contents continued

31 A Delivery System for Local Mental Health Services
by Leonard T. Maholick
from the *American Journal of Public Health*

34 Peer Group Supervision
by Rachel T. Hare and Susan T. Frankena
from the *American Journal of Orthopsychiatry*

35 Nonhuman Primates and Psychoses
by Harry F. Harlow and William T. McKinney, Jr.
from the *Journal of Autism and Childhood Schizophrenia*

38 The Contribution of Psychology in the Teaching of Psychiatry to Medical Students
by David Shakow
from the *Journal of Nervous and Mental Disease*

mental health and the law

41 Criteria for Involuntary Hospitalization
by Yorihiko Kumasaka, Janet Stokes, and Raj K. Gupta
from the *Archives of General Psychiatry*

44 **mental health news digests**

Moving Pictures as an Aid in Community Development

Alexander H. Leighton, Edward A. Mason, Joseph C. Kern, and Frederick A. Leighton

Planned community change faces two problems: what? and how? We are concerned with the latter question and, more specifically, with a relatively new technique. Cameras and magnetic tape have been widely used to record data, both for analysis and for illustration. Recently a number of people have employed the camera as an implement for inducing social and economic change.

Sociocultural Disintegration and the Problem of Change

The Stirling County Study which has been in progress since 1948 is examining the relationships between social and cultural processes on the one hand and mental health and mental illness on the other. The county—maritime, small town, and rural—is not socially or economically deprived, but it contains rural pockets or neighborhoods which can be so designated. In this connection a program of development using multiple techniques has been attempted. The program has a somewhat experimental design with "control" neighborhoods and communities for comparison.

The sociocultural disintegration of the neighborhoods may be summed up as functional deficiency in terms of: leadership, followership, inter- and intragroup communication, economic resources, family stability, religious and ethical standards, attitudes and sentiments that reflect conflicting or ambiguous values, apathy, short-range gratification, and present rather than future orientation.

We have formulated the following as characteristics to be changed:

Isolation—The inhabitants are typically isolated from the outside world and from their neighbors; there is little cooperative group effort toward common goals.

Self and community disparagement—This is apt to be exceedingly strong.

Powerlessness—The sense of fatalism and pessimism about life retards group cooperation.

Short-term motivation—The restricted time perspective and inability to make long-term plans is another widely reported feature.

These four major characteristics define goals for change in our experimental effort to help one neighborhood develop from a disintegrated collection of households to a community on a par with the general level of integration in the rest of the county. We began work by identifying needs felt by the people of the neighborhood and then aiding them toward achieving satisfaction. This meant focusing on activities advantageous to children, the formation of a community club, and the development of sports. These activities were a way of approaching the long-range goals of reducing isolation, self and community disparagement, powerlessness, and short-term motivation. They also provided a framework in which the people could expand their felt needs as they became more aware of possibilities and of means. Learning and modification of ideas and action went in both directions between research workers and the people of the neighborhood.

Moving Pictures as an Instrument for Change

In the Stirling County Study a system of interviewing that used a set of pictures as stimuli showed that

richer and more emotionally significant data would be obtained than by interview alone. The method included taking pictures as a result of information gained during an initial interview, then using these photographs to aid the respondents to express more fully their trends of thought in a second interview; this sequence might be repeated several times. There was no employment of the photographs for anything except evoking information and statements of feeling. Film researchers noticed two effects: One was that people began to come forward with ideas for additional topics; the other was that certain individuals began to introduce improvements in their ways of doing things. This came from not liking what they saw about their way of life and from positive feelings which stimulated them to want to do even better.

The "Movie Mirror" was formulated to reflect to people their capabilities and the assets of the region in which they lived, thus serving to counteract self- and regional-disparagement, sense of powerlessness, short-range motivation, and to replace these by positive feelings and effort.

The Movie Mirror

One of the neighborhoods under study was small, consisting of only 78 households; consequently, any work with a camera would be quite visible and all transactions would be highly personal. The photographer began in June 1967 getting to know the community and letting many of the people become acquainted with him. He lived in the neighborhood and made continuous field observations.

After a few days it was decided to introduce the movie mirror through the children. At this time a vacation school (part of the development project and run by college undergraduates) was in operation, and the photographer participated in the vacation school program until his face was familiar. Then, with permission from parents to take pictures, he began to seek acceptance from the children. He carried his empty camera about with him, letting the children handle it, press the buttons, listen to the noise, and peer into the lenses. After 3 or 4 days he was able to begin taking pictures without any apparent interruption or modification of what the children were doing. After processing, the footage which presented subjects in an embarrassing or unfavorable light was removed. The otherwise unedited film was shown to a large proportion of the people in the neighborhood and was received with apparent enthusiasm.

On the basis of the initial favorable reaction, ideas were sought for additional topics, and individuals in the neighborhood became informal advisors. One person became an especially valuable mentor, aiding the photographer to avoid acts likely to alienate people. He also explained prevailing sentiments in the neighborhood, suggested subject matter for pictures, and located people who could assist when assistance was needed.

In two summers the movie mirror was used for eight projects; two are described here:

The library float—As part of the development project, the wife of one of the authors conducted a Saturday morning story-reading session. This was concerned with reducing isolation by drawing the children's interest to things in the larger world outside the neighborhood. The readings were held in the community library in a town some 5 miles away and at-

tended by about 40 children. The organization for transporting children was part of the plan to reduce intragroup isolation and sense of powerlessness through encouraging patterns of cooperation.

When the town began to plan a day of celebration, the development project members and the Library Board suggested that the families in the target neighborhood might have a float in the parade. Such a task would require group interaction and had reasonable prospects for success. Also, in the event of success, movies of each stage in the development of the float could provide positive reinforcement by subsequent showings in the neighborhood.

The children were drawn into a discussion of possibilities, and they decided to build a large book depicting scenes from their favorite tales. They then tackled the task of deciding what committee each wished to join. This process provided opportunities for learning about making and implementing group decisions. The children brought many adults into the project: a carpenter to build the float, a truck owner to transport it, and mothers to make costumes.

The photographer filmed the various steps involved. Eight events were filmed and edited into a coherent 14-minute movie: the children reaching a group decision on the plan of action; executing the plan by joining committees; the carpenter constructing the pages for the book; the children illustrating and decorating the pages of the book; the book being mounted on a borrowed truck and decorations placed on the float; the children being picked up at their houses; the last-minute preparations; and the actual parade. Filming of the final preparations showed the pride and enthusiasm of the community, and films of the parade showed the recognition and acceptance accorded the float by the wider society. In short, filming of movie-mirror sequences was planned in advance and arose from a desire to illustrate for the neighborhood members the positive nature of the activity.

The film was shown seven times to a total of 226 people. Care was taken to reassure the neighborhood that the films were not offensive to the participants. The first showing was private at the home of the carpenter who communicated a positive attitude to his neighbors. The following day the showing was repeated in the home of a neighborhood leader. Our desire here was to furnish feedback to the neighborhood as quickly as possible. A few days later the first public showing was held at a local store and snack bar; 41 local residents appeared. This group represented the hard-core poor subsection of the neighborhood. Two days later the film was shown at a community hall, a formal gathering spot frequented by the more socially integrated members of the area. Some of the hard-core poor, however, were also drawn to this gathering, making a total of 75 local residents.

The first showing outside the study area was held in the nearby town; present on this occasion were town leaders and civic officials. The purpose was to demonstrate to the wider society the positive accomplishment and potential of their neighboring disintegrated enclave.

The film was repeated twice more in the neighborhood itself. Observations indicate that the project and film acted to reduce isolation, heighten cooperation, and produce attitude change. It drew people into the town to view the parade, and film showings in the community were an occasion for its members to get to-

gether. People who our previous studies had revealed as exceedingly isolated came to these showings. The film showed scenes both in the local neighborhood and in the nearby town. Hence, it demonstrated patterns of articulation with the wider society.

Attitude change was evident both in the neighborhood and in the wider society. The float won honorable mention from official judges of the parade. The neighborhood residents heard on all sides favorable comments about the float, comments very different from the silence or disparagement they usually encountered from outsiders. In addition, surprise was expressed about the accomplishment of residents previously thought to be unproductive. The town leaders present acted to open doors to the wider society by providing a reference group sensitized to the disintegrated enclave.

Within the neighborhood there was also evidence of attitude change. The film was a means of prolonging the positive effect, feelings, and sense of reward in the experience. The most articulate example was from the carpenter who had built the float; he said, "It really shows what can be done when people work together." The children conducted a followup project in which they wrote and illustrated their own books and entered them in a competition at the annual county fair.

Finally, changes were seen in neighborhood cooperation. The illustration of cooperative activity present in the library float film was used as a model of what was possible for the people of this neighborhood to do within their own resources.

Weir fishing—A weir is a large fish trap built on poles in shallow water. Its operation is dependent on the fact that fish move landward on a rising tide and out to sea on the ebb. It is during the ebb that long fences or wings guide fish toward the trap. Because the fish will not swim against the outward current, they are caught in the "pound" or large basin which constitutes the center of the trap. To harvest the fish, boats enter the pound, lay down a purse seine to lift the fish, pump them into their holds, and carry them to the processing factory.

Following the showings of the library float film, several members of the neighborhood who were connected with weir fishing suggested that we take pictures of that operation. We were glad to respond because it seemed to us that the dignity and drama of the work would interest those who had never seen the work being done and enhance the prestige of the fishermen.

Two additional considerations were the fact that a community club had shown people in the neighborhood a variety of films about workers in different parts of the world. Members admired activities similar to their own, and they appreciated dramatic scenery. Since the neighborhood is surrounded by natural beauty, we thought that a film report on the weir might heighten appreciation of the home region and suggest again the power that lies in cooperation.

The photographer accompanied the weir fishermen on their rounds, recording the process and responding to their suggestions about scenes of interest.

The first presentation of the raw clips was at the home of a weir fisherman who had been particularly helpful and whose family acted as informal leaders in the neighborhood. Several goals were realized in this initial showing: The fisherman was extended the courtesy of a preview; the dignity of his work was obvious;

the film offered positive feedback; and the family's favorable reaction was passed along to the neighbors. The first public showing was held at the community hall; 40 residents attended. Additional footage was taken based on the suggestions of the fishermen. The photographer edited the film and set it to music. The film was entered in competition at a film festival and won an award in the artistic division. When word of this reached the neighborhood through an article in the area newspaper, it had the effect of telling them that their work and neighborhood were approved by distant members of the larger society.

The next showing was held at the local neighborhood informal gathering spot (store and snack bar). About 30 people attended, and we were requested to repeat it the following evening at a private home. The weir fisherman who had been particularly helpful, as well as some leaders in the area, was present.

The nearby town, which was the prime reference group for the neighborhood, held an annual Chamber of Commerce meeting attended by 250 people including political, civic, welfare, religious, and professional leaders. One of the authors showed the weir film to indicate a productive side of the disintegrated area and to alter opinions about the potentiality of the neighborhood.

The weir film was repeated twice in the neighborhood itself and was designed to remind the neighborhood about the dignity of this work.

Field observations in the neighborhood and at the showings supported the assertion that the film helped reduce self- and community-disparagement. The fishermen's families commented time and again with pride. There was a rise of interest in weir fishing, and the fishermen were sought out by their neighbors for advice.

Equally important was the reaction of the town. Many people at the Chamber of Commerce presentation were startled to find that people about whom they had a low opinion were engaged in such productive work. The film also had the effect of suggesting that the neighborhood residents were engaged in a thing of beauty. Opinion by the significant reference group moved toward a more balanced and favorable view of the neighborhood.

The positive effects of the library float and weir-fishing films encouraged us to undertake other movie-mirror projects. These included the life at sea of a neighborhood member working as a cook on a fishing trawler, the progress of a community garden, the development of a softball league, an educational trip to a university by a group of teenagers, the functioning of the vacation schools, and a record of various social events and community club meetings.

We feel that the movie mirror can be an important aid in community development. It is demonstrably a low-cost method with wide potential for mobilizing community feeling and action. Its use, furthermore, is feasible in conjunction with other efforts.

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Reprints of original article from Alexander H. Leighton, M.D., Professor of Social Psychiatry, Chairman of Department of Social Sciences, Harvard School of Public Health, 55 Shattuck, Boston, Mass. 02215.

Sectorization: The Quiet Revolution in European Mental Health Care

Martin Gittelman

Faced by a health crisis of immense proportions, our nation and our profession seek solutions to the problems of health care. With health-care costs rising at a rate of 15 percent a year, it is clear that private, fee-for-service psychotherapy will soon be priced out of the market. Another consequence is that our best-trained professionals in private practice will increasingly be treating the less-impaired, because they will be the ones who can afford it. Is it any wonder that there are demands for new funds to pay for mental health treatment?

That some form of national health insurance with psychiatric care will be adopted seems clear. What is less clear is whether such a plan will result in basic, rational restructuring of our present mental health delivery system. Without such a reorganization, our profession will continue to provide second-class or no treatment to the poor, the long-term patient, and the mentally retarded—the unattractive and the "unaffluent" patient. The problem is not the application of new theories or techniques, but more effective use of our professional resources—knowledge, manpower, and facilities.

Decades ago many of the technologically advanced European countries turned to national efforts to solve the problems of funding, reorganizing, and upgrading health-care services. As we seek new solutions, it is important to study and analyze their experience.

National Health Insurance vs. National Health Service: What's in a Name?

Although almost all Western European health systems are supported by some type of funding called "national health insurance" or the "sick fund," they bear little resemblance to the plans being proposed on our political scene. Only England, Spain, and Turkey actually call their systems a national health service.

National health insurance and a national health service differ most with respect to their funding and, in the case of the former, their eligibility requirements. Under national health insurance, funds come from employee, employer, and national (graduated income tax) sources; under a national health service, funds are derived primarily from taxes, though patients may be charged a small fee to discourage overutilization of the services. Under national health insurance, eligibility varies, some groups (e.g., unemployed, farmers, the affluent) being ineligible; but the trend is toward expansion of eligibility to cover almost everyone. What is important is that in every European country national health insurance is not only a funding mechanism but also has service components.

A Comparison of Systems

Apart from the method of financing their systems, there are similarities among all of the European countries.

European mental health systems seem to have an enormous base and small superstructure—if one conceives of the base as largely public (planned and financed by tax and/or insurance funds) and geared toward the treatment of chronic mental dysfunction. The United States, on the other hand, has an immense superstructure and a small base. We treat

the "worried well," the mildly neurotic, those with the inner resources to actualize and "potentiate" themselves (with a little help from friends and therapists); but we have difficulties in working with those with serious, long-term, emotional disorders. For the treatment of the latter, we have the mental hospital, which, has iatrogenic effects on its patients (and probably on staff members).

In an effort to bridge the gap between the mental hospital and outpatient treatment, the community mental health centers were created. But these centers have never been on a firm financial footing. The need for matching funds has prevented their being set up in places where they are most needed. Moreover, under the legislation that created them, Federal support declines from 75 percent to zero in less than 5 years. Without an alternate financial base, these centers will not do the job they were designed for.

The Europeans have never had community mental health centers, as we conceive of them. Their primary reforms have been directed toward the mental hospital and the extension of its functions into the community. The Europeans are frank about their reasons for trying to reduce the number of patients in mental hospitals—it was too expensive!

Community Psychiatry is Psychiatry

In 1966, when I started visiting European mental health facilities, the authorities didn't know what I meant by community psychiatry. Like Molière's character who was talking prose but didn't know it, the mental health authorities were practicing community psychiatry but didn't recognize it as such. Actually, almost all psychiatric facilities in Europe are "public," that is, accessible to the public. Even private institutions receive funds for their operation from tax monies or national health insurance. The point is that community psychiatry is not considered a "specialty"—psychiatry is community psychiatry.

To be sure, private practice flourishes. Many of those who work within the public sector have private practices to supplement their income. The consumer is free to choose either public or private treatment, but is reimbursed in either case. Only in psychoanalysis are patients occasionally discouraged from using their social security benefits for treatment.

The public sector has little difficulty competing with the private sector for professional staff or even for patients. Professionals vie to enter the public sector, but because of stiff examinations not all make it.

Innovations

There is little in European mental health systems that one cannot find somewhere in the United States. There are some rather impressive architectural successes; on the whole, though, construction of new facilities is deemphasized. Old buildings in the community are remodeled to accommodate new services. In some countries I was told that never again would a new mental hospital be built, though small units in the community for partial hospitalization and outpatient treatment might be constructed. Some of the finest buildings I have seen were built for the mentally retarded and the senile psychotic. What a reordering of priorities!

There are a few developments in mental health care, particularly in the training and use of professionals such as educateurs and psychomotor and graphomotor specialists. But these are not the most important innovations. The advances are in or-

ganization, designed to assure better delivery of care.

In general, mental health care in Europe seems more humane and personal than in the United States. For example, vacations are mandatory for residents of institutions for the retarded in Scandinavia, and experimental programs in arranging vacations for mental patients as well are under way.

Historical Trends

The impetus for changes in European mental health systems came about the time of World War II from three sources: economic; modernization of hospitals; and democratization caused by wartime pressures. With the advent of psychotropic drugs, greater impetus was given to these trends. Patients were discharged into the community—but they needed aftercare. To minimize the problem of staff travel all over the countryside, sectorization was started.

Sectorization involved dividing up the population by geographic sectors and assigning responsibility for each sector to a mental hospital. Recently smaller sectors have been created as more staff has become available. Experience has shown that small sectors are more efficient and effective in reducing rehospitalization.

Thus patients began to be maintained within their communities. As facilities for treatment have become available in the community, the number of hospital beds has been reduced. Increasingly hospitalization is viewed by professionals as a result of failure to provide adequate treatment facilities in the community.

The trend, then, is toward:

- Democratization of the hospital to make it more like the real world than a prison.
- Reduction of hospitals—move the patient *and* the staff into the sector or community aftercare facilities.
- Elimination of the mental hospital. Mental hospitals will be replaced by crisis-intervention teams, small hostels, halfway houses, apartments in housing projects, sheltered workshops, and partial-hospitalization centers.
- Opening of community mental health facilities to nonchronic patients, ranging from those with neurotic and character disorders to the "worried well."

Because almost everyone is eligible for treatment in a public mental health facility, it is natural that the outpatient facilities, originally set up to provide aftercare, have begun to treat many who would be treated in our outpatient departments—people who might never have found their way into this type of treatment center. Herein lies a great benefit of a national health insurance system: What starts out as a more effective means of caring for the chronically ill becomes the base for treating the less severely ill and for practicing preventive psychiatry.

Another effect is change in community attitudes toward the mentally ill, a change toward greater acceptance with greater familiarity. Tax benefits to employers who hire former mental patients have been instrumental in integrating many patients into the normal world.

Organization and Structure of Services

In most European countries mental health treatment is a planned affair. The mental health service is viewed as a necessary and integral part of life. like educational services. Since funds are available through tax monies and health insurance, a rational ordering of national priorities can be formulated. Although top priority is given to the seriously and

chronically ill, in the past few years mental health planners have moved toward greater consideration of the problems of those who are not mentally "ill," but who require skilled assistance.

Mental health planning and operation are organized on three levels. At the *national* level, planning, programs, and policies are determined. Although the national authority arranges for financing and set standards and priorities, it does *not* control the organization and delivery of services. Coordination of services and personnel within a geographic area is done at the *regional* level. Provision of services is managed at the *community, district,* or *sector* level.

At the national and regional levels, operations are directed by a stable bureaucracy which makes long-term planning possible. At the regional level, demographic and epidemiologic surveys are undertaken to assess the prevalence of mental disorder in a given community. Personnel and funds can then be distributed in a rational manner; geriatric patients, the retarded, and patients requiring long-term care can be allocated their share of funds and personnel, rather than be shunted aside.

Throughout Europe therapy tends to be similar to American forms: psychotherapy and medication, but the emphasis is on adaptation to family and community living and on maximizing the possibilities for work. Work competency programs are most advanced in England where 100 of 120 mental hospitals have industrial training units. In Eastern Europe, psychiatrists may prescribe fewer hours of work for mental patients who suffer no loss of pay as a result.

Home visits are an important part of community treatment. In some sectors visits are made by the entire team; and homemakers and visiting nurses are a valuable adjunct to therapy. Continuity of treatment is ensured by the services of a full-time, mobile staff, which works in the outpatient and inpatient facility.

In many countries there is no longer a dual system of treatment for the affluent and the poor. Since health care is paid for by all, there is a tendency to use the existing services and to demand quality care.

Finally, these systems lend themselves to research, particularly in epidemiology and operational studies. With the development of case registers, studies of the causes and prevention of mental illness become easier.

Needs and Un-Needs

In the United States, when we have a problem, we tend to *build* around it—hospitals, highways, drug addiction centers, etc. And our model has been—let's build it big to make it more efficient.

The Europeans think small: small clinics, small teams, serving small communities. They try to keep everything cozy and homelike and human, which is the way it's supposed to be in mental health care.

Most important, Europeans are service oriented. When they start a service, whether it's a halfway house, a sheltered workshop, or a treatment facility for children, they almost never begin by building a building—which is apt to be outmoded by the time it is finished in any case.

Fee-for-Service System

The fee-for-service system can never serve as the basis of a comprehensive health system. This is particularly true in mental health; much of the service provided by therapists in sector mental health can't be measured, tallied up, and paid for. One by one, countries

in Europe are dropping their reliance on the fee-for-service arrangement to provide mental health care.

Financing and Personnel

Merely providing more money for existing services will not produce more or better services. The issue is not more money, but how the money is spent. In mental health, much money can be saved by providing alternatives to institutional care, downgrading construction, and facilitating early treatment by removing the financial obstacles to such treatment. Most European countries get by with fewer highly trained mental health professionals. They would like to have more but they don't cite lack of professionals as a main problem.

The Real Need: Better Delivery of Services

The answer is better delivery of mental health services, achieved through reorganizing our thinking and funding, and our operations. Mental health care has to become accessible and financially feasible in the patient's own community. The community mental health center concept was a step in the right direction. But it didn't go far enough; it wasn't, in most instances, built around a mental hospital, as it should have been; it wasn't adequately financed; and long-term needs in personnel and facilities were not provided for.

Even the affluent cannot get good mental health care in the United States. They can afford treatment in expensive private centers, but what happens once they are discharged? Some private institutions have created artificial communities as a means of bridging the gap between hospital life and life "outside." Such communities are no substitute for the patient's own milieu, in which he must make his way.

A public mental health system, based on the community, has another advantage: It makes preventive programs possible. We know that public health measures aimed at prevention are more effective and far-reaching than the most advanced and expensive treatment procedures. For both the affluent and the poor prevention is better than cure.

Unless we build a national, regional, and community network of services, we shall never be able to restructure and redirect our priorities to the care of children, the long-term mentally ill, the retarded, the disadvantaged, and the rural communities. Unless we build a regional system, all these groups will continue to fall between the cracks of fragmented services. Someone, somewhere, must assume responsibility for them. We must move with all possible speed to fulfill our responsibility for providing the best health care of which we are capable to all the people.

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Reprints of original article from Martin Gittelman, M.D., Chief, Children's Service, Queens-Nassau Mental Health Service of the Health Insurance Plan of Greater New York, 89–14 168th Street, Jamaica, N.Y. 11432.

The Community as a Social System

Frederick L. Bates and Lloyd Bacon

Community as a concept is employed by virtually all students of complex social systems, yet sociologists are aware how ill-defined and imprecise is the concept of community. This paper attempts a logically consistent and empirically usable definition of community to reduce the confusion and ambiguity surrounding community as a concept and its behavioral referents.

Certain assumptions underlie this effort: The definition of community should facilitate the gathering, classification, and analysis of empirical observations, and it should operate as a theoretical guide to research. The concept of community should be consistent with concepts employed in analyses of other social systems, and the structural properties of communities should be identified unambiguously so that changes in them can be measured empirically.

A sociologically adequate conceptualization of the structural properties of the community as a complex system of social behavior must include statements about: the units that comprise the community; the internal relationships of these units; the boundaries of these relationships; how systems of behavior are linked across boundaries to produce ever more complex social entities; and how communities differ structurally from other social systems.

Conceptual Problems

The minimal requirements for constructing a theory of community have not been met satisfactorily for a number of reasons. One important reason is that several traditional assumptions permeate thinking regarding communities and interact with each other to produce inconsistencies. These assumptions are impediments to the development of more adequate theories.

The first is the *geographic assumption,* the tendency to define the community as a physical area with identifiable geographic boundaries. This orientation precludes consideration of the essentially social nature of the community; the community exists in social space and only incidentally occupies a geographic location.

The *humanistic assumption* is the assumption that communities consist of people as units. However, communities are systems that persist through multiple generations, transcending the lives of individuals. If community continues as its members change, people as biological or even as social beings cannot be regarded as constituent units in the community system.

It is also necessary to reject the view that communities consist of families served by a system of social services. Families are behavior systems which comprise only a part of the total community system. The units or parts of the community as a complex system of social behavior are the specialized behavior systems that are linked together through interpersonal behavior of social actors.

The third assumption, the *romantic,* is the assumption that communities are systems of cooperating individuals or groups oriented toward common goals and purposes.

The point taken here is that the community is not a system of cooperating human beings seeking common goals, but is a system of competing, conflicting behavior where need stemming from interdependence often

engenders exploitation and hostility rather than cooperation and mutual aid.

A Conflict Model of Community

The division of labor creates a situation of interdependence among the behavior of individuals, groups, and organizations, and in so doing fosters the possibility of one group exploiting another through the exercise of power. In other words, the basic social processes which give a distinctive character to the community as a social entity are the processes of conflict and competition, not the processes of cooperation and mutual aid.

Communities are viewed here as social systems within which are mitigated and controlled the processes of conflict and competition. Furthermore, communities are social systems within which individuals satisfy needs through relating to other individuals, groups, and organizations that have distinctly different and sometimes conflicting orientations. Constituent parts of the community system, through the division of labor, depend upon one another for the performance of various specialized behavior necessary to their survival. Such interdependence, rather than creating automatic cooperation, induces conflict.

The view is proposed that *community* is a complex social system with unique structural properties that enable the management of conflict and competition arising out of the functional necessity to exchange social products. The structure of this system, in turn, is viewed as a consequence of the division of labor in society.

The Structure of Community Social Systems

Social relationships—The distinction between reciprocal and conjunctive relations is a consequence of orientations of the behavior of actors occupying positions involved in social relationships. A reciprocal relationship exists when positions occupied by two actors are oriented toward performance of the same general function, and thus may be regarded as parts of the same system of action. In conjunctive relationships, the parties involved pursue separate and distinct goals and perform separate and distinct functions for analytically separable systems of action. Conjunctive relationships lie at the core of community structure where groups and organizations are linked for the exchange of goods and services.

Within communities, groups and organizations cannot exist alone since they represent specialized action systems which perform only part of the total behavior necessary for the survival of each specialized system and individual actor. There must exist within the structure of each interdependent group and organization a mechanism to join it to the other parts of the social system which furnish it with, and receive from it, needed products and services.

Group relationships—Extramural social roles link specialized systems of behavior together by thrusting the actor out of one system into another. The differentiated presence of extramural roles within positions and groups constitutes an empirical measure of the amount of interdependence of actors and multiperson systems associated with the division of labor in society.

The type of group created when the actor is required to leave the boundaries of one group and enter the boundaries of another group in order to secure needed goods or services is an *interstitial* group. An interstitial group stands between two *ele-*

mental groups and has the function of effecting a transfer of goods and services (or functions) from one group to another. Interstitial groups always contain representatives of two or more elemental groups. Within the structure of such interstitial groups lies the conjunctive relationship between members.

It is possible to identify two broad classes of interstitial groups based on their structure in terms of relationships:

Exchange interstitial groups are commonly organized around either the professional-client relationships or the merchant-customer relationships. They exist when a large number of groups or organizations receive some needed product(s) from a small number of groups or organizations—for example, the relationship of families to a grocery store.

Families are classified as elemental groups, and the grocery store constitutes another elemental group. Between these two elemental groups exists an interstitial group within which an exchange takes place in a conjunctive relationship. This relationship is common to all exchange interstitial groups that link one organization to another.

In the exchange interstitial group, one position is occupied by the same actor in a large number of cases. Actors occupying the other position change according to the client or customer involved.

A *coordination interstitial group* manages relationships among two or more distinct groups or organizations with differing and potentially conflicting interests. In this type of interstitial group, each position is occupied by one or more persons representing the interests of a different group or organization. Unlike the exchange interstitial group, which is repeated over and over again with one member remaining stable, the composition of this group is unique. Each member or group of members represents a different organization's or group's interest.

An example of a coordination interstitial group is a Chamber of Commerce. Members of the Chamber may represent the interests of a dozen different groups and organizations; relationships among the positions in such groups are classified as conjunctive since the interests of each one of these organizations and the functions that they perform are distinct and potentially in conflict.

Coordination groups may take at least two forms—*factional* or *nonfactional*. In a *factional* coordination group the members form two subsystems comprised of individuals joined to each other by reciprocal relationships. These subsystems, or factions, are related to each other in terms of conjunctive relations. In a *nonfactional* coordinating group the relationships between actors are all conjunctive within the interstitial group.

Other dimensions of coordinative interstitial groups can be examined. One of the socially important variables is that of function, or how specifically structured community processes control and manage the dynamics of conflicting interests and behavior of specialized groups. On the basis of the community-relevant processes that occur within coordinative interstitial groups, five subtypes can be identified:

1. Task oriented or executive—directs or focuses activities of community
2. Judicial—adjudicates disputes
3. Legislative—establishes rules to govern conflict processes
4. Pressure—focuses energies of change agents on particular organization
5. Buffer—absorbs or diffuses potentially

disruptive conflict directed at specific organizations

Examples of the above coordinative interstices would be: task oriented—board of county commissioners, citizens committee for the performing arts, hospital volunteers association; judicial—court systems, labor arbitration boards, grand juries; legislative—school boards, better business bureaus, local professional ethics boards; pressure—political parties, labor unions, environmental conservation clubs; buffer—P.T.A., interracial councils, citizen advisory boards, company unions.

An increase or decrease in the number, scope and potency of these coordinative interstitial groups constitutes an important aspect of community dynamics, and these variables may be investigated empirically.

Research implications—The notion of interstitial groups enables the development of a more logically consistent theoretical construct within social system analysis. The conceptualization of exchange and coordination interstitial groups that contain conjunctive relationships provides the criteria by which *community* is rendered analytically distinguishable from groups and organizations.

By using concepts employed in the analyses of small groups and organizations (norms, roles, positions, etc.), consistency in the analyses of communities as systems of behavior can be achieved. Then the behavior observed in communities can be described and analyzed in terms of observed similarities and differences in structure.

Furthermore, research done on community behavior, or social behavior within the community setting, will reveal more sociologically meaningful findings to the extent that analyses focus on interstitial groups existing in the communities as social systems. The number of extramural roles and resultant interstitial groups formed within systems may prove a fruitful way to operationalize the concept of division of labor, and to use this variable as a key indicator of the direction and magnitude of social changes.

Interstitial groups, having at their core conjunctive relationships, link groups and organizations within communities, yet conjunctive relationships are potential sources of conflict. The structure of interstitial groups, however, has the function of managing intergroup and interorganizational relationships in such a way as to control conflict in order to insure the necessary transfer of products from one group or organization to another. This type of structure sets communities apart as a type of social system from organizations and from groups.

It follows from what has been said that research on the community should focus its attention upon interstitial groups and particularly on conjunctive relationships within them, using concepts whose referents are sufficiently unambiguous to allow other sociologists to be informed of precisely what is being defined, described, and analyzed.

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A National View of Transitional Living Programs

Lucy D. Ozarin

It is likely that the 1970's will see a leap forward in the development of transitional living programs. The impetus will come from many sources: changing attitudes about the mentally ill, prisoners, elderly people, and other groups; changing professional traditions and attitudes; research findings that contribute to development and refinement of transitional living programs; Federal legislation supporting transitional living programs.

People who need or could use transitional living programs may be classified several ways: By age—preschool children, school-age children, adolescents, adults, and the elderly. By problem—neglected, dependent, or physically helpless children; mentally retarded people; people released from State hospitals; alcoholics; drug addicts; those released from prisons; delinquent youth; and the elderly who need protected living. Each of these groups has different requirements, and different laws and grant-support programs apply to them.

I would like to stress one point: The living facility and its staff is only one part of a program. The halfway house must be buttressed by supportive and backup services; it must become an integral part of the community and its institutions.

Providing community care for the mentally ill and new treatment methods have resulted in the diminution of mental hospital populations. California has closed two State hospitals and several more are slated for closing. Massachusetts is about to close its first State hospital. Kentucky is considering turning over the State hospitals to local groups. Idaho has talked for some time of closing its two State hospitals. Iowa also has made such proposals. As community facilities become available and State hospital populations become smaller, we will see more State hospitals closing.

But closing State hospitals solves one problem and creates another—providing supportive services for handicapped people who live in the community. Many ex-patients do not have families, and many are living in boarding homes and nursing homes. Some hospitals have tried to provide supportive services, but usually these have not been adequate. The high readmission rate to mental hospitals bears a direct relationship to the followup care provided.

NIMH has supported research on transitional living. The results indicate that whenever a new kind of effort is made it usually works, regardless of the kind of personnel or the kind of living facility. The research supports the need for an integrated system of care to support those who move from transitional to independent living.

Communities with mental health centers are often pushed to the establishment of halfway houses because of sheer necessity. Each community decides on the basis of its own situation whether a halfway house will be under the aegis of its own board or will become part of a mental health center. Most halfway houses have their own boards. In San Francisco the Westside Consortium is affiliated with two halfway houses serving young adults. Since the halfway houses are tied into a system, medical, psychiatric, and social work services are available. The Sound View-Throgs

Neck Mental Health Center in the Bronx established a halfway house under it own aegis. This is an apartment for patients who move into independent living; it is across the street from the day care center and is part of the total system.

Halfway houses operate on an authoritarian basis or on a communal basis. Most halfway houses run as self-governing facilities, although there are some, especially nursing homes and homes for ex-State hospital patients, which are run in an authoritative manner. This poses a task in training houseparents. Some of the community colleges and universities providing mental health training to paraprofessionals may be able to provide didactic training in this aspect. Or mental health workers trained in educational institutions may be recruited into the houseparent jobs.

The new thrust in alcoholism programs will lead to an increase in halfway houses. The requirements for Federal support stipulate that intermediate care be available, which means residential living for alcoholics who so often are unattached. These houses are usually managed by ex-alcoholics but are tied into a supportive system of services.

In many places halfway houses for drug addicts have been established. Synanon is famous for its system of building self-responsibility into the individual. Homes for alienated youth, especially those who have been involved with drugs, are coming on the scene. Often the clients are from middle socioeconomic families.

While much national attention has been focused on care of the elderly, we have not gone far in making nursing homes and boarding homes better places to live. Children have received little attention, and yet they are the group with the greatest potential to profit by appropriate programs.

Financing is crucial. Funds are needed for support of the clients—board and room. Welfare payments are usually relied upon. Families may be able to pay, or veterans' pensions and benefits may be available. Vocational rehabilitation can supply living costs for some clients. Funds for staff may be drawn from mental health center funding of State grant-in-aid. HIP grants to State hospitals may be used. Staff consultation to nursing and boarding homes is available from mental health centers or other existing facilities. The major task is to develop an integrated network of facilities so clients/patients can receive the care they need at a given time. Community organization is a prerequisite to the establishment of a halfway house.

On the national, State, and local level, we have a variety of decisions to make. We need to look into the local needs for transitional facilities to find what resources we have available or can develop. Then we must decide how we will proceed to spend our resources. We will have to determine our priorities and then move to deal with them. It is no small task and it will never be completed because priorities change, needs change, and resources change.

Condensed from a speech delivered April 1972 to the Kansas Conference on Transitional Living Programs at Topeka Veterans Hospital, Topeka, Kans. Copies of speech from Lucy D. Ozarin, M.D., National Institute of Mental Health, 5600 Fishers Lane, Rockville, Md. 20852.

Mental Health Planning and Evaluation for the Black and the Poor

Alyce C. Gullattee

Popular Definition of Mental Health

We rarely analyze our individual conceptualizations of the meaning of mental health. However, our tendency to equate mental health with recovery from mental illness seems to be entertained at least at a subconscious level. It is as if there were a global acceptance of the idea of mental illness that motivates or generates our concerns about this vital aspect of the national psyche. The popular definition of mental health is to be free from mental illness, with the latter ill-defined and amorphous in terms of acute and chronic processes and with varying degrees of recovery.

We think of mental health in terms of other people, and the government deals with the issue of mental health that embraces the type of services being provided. Mental health services and psychiatric services are equated.

Operational Definition of Mental Health

Mental health is a part of that complex entity called total health. In this regard psychological and physiological components are delicately interwoven. There are multiple factors and stimuli that impinge upon the developing individual and strengthen or weaken the basic matrix of his health. The components are in part socioeconomic and cultural. The systems—familial, neighborhood, community, structured institutions of local and national government—all play a part in the health sequence. An operational definition of mental health must include these elements and must be a positive entity rather than the end product of a negative one. Mental health is that condition existing in the individual which allows him to function in a societal framework that may be deprived by national standards, hostile by ethnocentric ideations, and punitive by social imperatives. Mental health is multifaceted and multidimensional in its adaptational and moment-to-moment nuances. It is the sum total of one's behaviors which allow for survival (within the framework of cultural reasoning) with the least amount of compromise of one's personal philosophy and object identity.

The Question of Mental Health

In this instance "question" rather than "problem" is preferred because of the neutral quality of the word. Question does not carry with it a negative connotation but denotes an attitudinal openness toward and serious inquiry into the subject of mental health.

Incidence—In 1967 there were 289 mental hospitals throughout the United States and they housed an estimated 500,000 people. One-third of the U.S. population was believed to be impaired at some time by symptoms of mental illness during 1967, but many obviously did not require hospitalization. Admission rates to State and county mental hospitals in 1969 indicated that the highest admissions were among nonwhite males in the age group 35–44 years with 753 admissions per 100,000 population.

The nonwhite admission rate to government mental hospitals has always been higher than for whites. In

1930 nonwhite rates were 2.3 times higher; by 1950 the rate was 2.1 nonwhite. Statistics on age at the time of admission for 1969 indicate that the median age for white males was 42 years and white females 43. The median ages for nonwhite males and females were 36 and 35 respectively.

Diagnostic categories indicate that the incidence of alcoholism is three times greater among white male and female admissions than for nonwhites. Schizophrenia is diagnosed twice as often in nonwhite males and slightly less in nonwhite females, but the overall incidence is greater in the nonwhite hospital population.

The highest admission rate (1969) for all females, nonwhite and white, was in the 35–44 age group with 303 admissions per 100,000 population. Male admission rates in almost all diagnostic categories were greater than females in 1969. The only age group that showed a greater preponderance of females was the 14–17 year, nonwhite admissions.

In States where the elderly are placed in mental hospitals there has been an increase in the proportion of patients age 65 and over. This increase has occurred in spite of decreases in overall admissions.

Institutional attitudes—A philosophy that clearly defines and embraces an ideology of mental health has not been articulated. Each agency that provides advocacy services in mental health develops its own guidelines and goals. The areas of health, education, and welfare demonstrate the varied cultural capacities for mental health resulting from differing levels of service that are made available to the American people.

Cultural attitudes—Societal attitudes imply that mental health is a privilege and not an inalienable right. If we compare treatment facilities and modalities available to the poor and to the economically privileged, the distinction is obvious. Mental health care for the poor is provided in government-supported mental hospitals. These hospitals become the repository for blacks, whether poor or of moderate means, if extended hospitalization is necessary. Only in recent years have blacks been accepted in private residential treatment centers. This can be attributed primarily to ethnocultural attitudes and in part to economics. Few families can afford the high cost of private psychiatric treatment.

There are small numbers of poor or economically underprivileged whites who are treated in government hospitals. They have been likewise victimized by the stereotypic attitudes of white familio-cultural exclusionaries who make up the treatment teams.

The elderly comprise the poor who by virtue of societal-cultural attitudes are forced into economic compromise. For years white administrative staff attitudes supported the thesis that the poor, the less educated, and the nonwhite could not benefit from psychodynamic modalities of psychotherapy. Custodial care provided by staff and noncompensated-work patients constituted the primary therapy. To a large extent this continues to be true in most government hospitals. Where vocational and industrial therapy programs have been instituted, patients continue to be exploited, some receiving 15 cents for an hour's work.

Through reinforcement of negative attitudes of the culture and the profession about the ability of the emotionally disturbed, we promote a declining sense of personal worth and thus chronicity.

Familial attitudes—There are many

conflicting views about the nature of mental illness. Family and physician often differ about the "diagnosis" of a symptom complex. The family system never extrudes its member until the behavior becomes so aberrant that it can no longer contain the member without risk of harm, first to internal family cohesiveness, and second to the external cultural imperatives. This is particularly true in the "privileged" poor white family where societal acceptance is needed but not necessary for "stump" survival, and in the nonwhite family where societal acceptance is seen as economic acceptance, and understanding of nonwhite social norms by whites are deemed impossible.

This dichotomy of opinion leads to problems revolving around lack of early diagnosis and in some cases longer periods of hospitalization. However, for a great many people it prolongs their period of productivity and helps to define for the professional a level of work tolerance or system survival, and for the patient a sense of personal worth. This knowledge can be effectively used by the perceptive mental health worker to aid the patient and the family.

Historically, blacks were presumed to be incapable of having certain forms of emotional disturbances. Therefore, the mental illnesses of nonwhites were associated with their having been exposed to physical illnesses, primarily syphilis or dementing fevers. This resulted in many nonwhites being diagnosed as having some remnant of tertiary syphilis. From 1869 to 1954 this was the major diagnostic category for blacks.

Poor whites were looked upon as genetically and intellectually compromised or suffering from the most regressed form of schizophrenia. The families of the poor and the poor patients were often not understood—literally and figuratively—by "mental health" specialists, most of whom were foreign born or trained. Because of this lack of knowledge about the cultural and familial nature of illnesses and preformed ethnocentric ideas of the mental health professionals about the poor, many poor families continue to "work" home remedies to "bring a person back to self." This has preventive medicine implications for the physician who sees such patients long before hospitalization is necessary.

With cultural and familial definitions of mental health differing from institutional definitions, family members, depending upon the sociocultural system from whence they come, are willing to accept the patient at home when the behavior approaches "normal" by "their standards." There are implications for training of mental health personnel inherent in this type of orientation for community reentry and followup care.

Objectives of a Mental Health Program

No mental health program can justifiably be separated into provinces of responsibilities. Mental health programs must be woven into the fabric of community health programs. No illness is looked upon as being so radically different that "special" isolation is necessary, adding a negative stigma to it. One unfortunate failure of community "mental health" centers is that they have tended to perpetuate the idea of "being different" by being apart from comprehensive medical care.

Poor peopie do not separate health, only sickness, and tend not to view mental illness as a lasting phenomenon but as a transitional one for which the person will be "cured." In their early years mental health centers

served as extensions of sociological study centers of the poor and rendered minimal service to the poor constituency. They tended more to enrich the care for the middle-class paying clientele and offer academic opportunities for the "chosen" staff.

The task set for community mental health centers was ambitious and unrealistic in light of the lack of trained personnel with knowledge about the community systems of the poor and some systems-analysis background.

It might safely be said that two phenomena have worked to reduce the incidence of inpatients in mental hospitals. One has been the humane orientation by the public toward the emotionally disturbed. This has created a more realistic opportunity for the mentally ill to reenter the mainstream of life; also the increased incidence of anxiety reactions associated with transitional periods of life adjustments and certain neurotic disorders requiring little if any hospitalization have made possible short-term hospitalization in private psychiatric centers or nonpublic general hospital psychiatric beds. The second phenomenon is associated with the softening attitude toward the mentally ill, allowing the setting up of local convalescent leave or outpatient followup clinics in the community.

Education of the public—Educational efforts should be positive in orientation. Too often the phenomenon of human development with its multiple and multifaceted transitional phases is omitted from mental health programs, in some cases because of ignorance, in others because the instructor decides that the public wouldn't understand or appreciate the importance of this phenomenon. A large segment of the public, therefore, remains ignorant of the natural human processes of depression, anxiety, withdrawal, avoidance, etc., a knowledge of which would help them adapt, adjust, and perform more effectively as human beings.

Research capacity—The ability to devise and conduct research requires perception, sensitivity, and awareness of mental health needs in the community. Not all centers can successfully conduct research because of the potential conflict between advocacy responsibility and the tenets of research models. The community becomes suspicious of research that is not oriented toward improving the socioeconomic status of the individual, the family, or the neighborhood systems. The capacity successfully to integrate research into programing by mental health staff is a function of its ability to see areas of related needs within a framework of service.

Design of pragmatic mental health programs—All programs for the poor and near poor should have clinical and community components combined. The needs of people who cannot afford the leisure of prolonged illness dictate the treatment that must be available. Since inpatient psychiatric beds in general hospitals and most mental health crisis centers are limited, availability of clinical services can be provided by State mental hospital facilities. Plans for vocational rehabilitation, continuation of work status, and community living should begin immediately upon admission rather than as a part of aftercare. The components of such programs would consist of precare, inpatient, and outpatient.

Developing a therapeutic capacity adequate to identify and service a target clientele and provide preventive programs—There are too few mental health professionals who have adequate knowledge about the mental health needs of the poor and speci-

fically the black. It is not adequate to receive middle-class psychoanalytic training in an academic atmosphere and expect to apply the principles to the poor community. Therapeutic capacity incorporates training and on-the-job experience.

It is an unfortunate fact that the National Institute of Mental Health had never had one black psychiatrist on its staff until it absorbed Saint Elizabeths Hospital in 1967. Fewer than one-tenth of 1 percent of minority psychiatrists have benefited from the millions of training dollars made available to NIMH. There has been little incentive and encouragement among those trained at the expense of the government to become institutional (i.e., poor population mental health) therapists.

Identification and prevention are closely aligned, and service bridges the gap between education and therapy. A sensitive level of awareness coupled with adequate training is imperative.

Involving non-governmental agencies and institutions in the development of mental health programs—The lives of most of the population revolve around agencies that are nongovernmental, in the national sense. At the nuclear level, however, we have systems that may be quasi- or pseudogovernmental impinging upon our development. These systems, to name a few, include the churches, schools, economic resources including labor organizations, housing developers, service and social clubs, political groups, and extended family groups living in tribal arrangement.

The church has been delegated the role of saving the soul rather than keeping the body whole. As a therapeutic form it has yet to be fully explored. The school expands one's intellectual capacity instead of developing the capacity to utilize the intellect. The therapeutic forms of reaction, of the extended family, and the need for therapeutic occupations for individuals demand study. Social and service clubs play an important role in moment-to-moment therapy and need fulfillment for their participants. The potential for development of nonpathology-oriented programs is boundless from this resource group.

Effectively utilizing paraprofessionals in mental health programs—The greatest manpower pool in mental health—the nursing assistant—is often neglected. During the dark years of treatment for the institutionalized mentally ill, the only ray of hope rested with these dedicated people.

All members of a team who touch the life of a patient become behavior modifiers. That includes the housekeeper, dietary worker, maintenance help, as well as nursing personnel. Coupled with the academic instruction about mental health processes is on-the-job training or exposure to the expressive modes of the varying levels of mental health in patients who are hospitalized or on leave in the community.

We have seen in the past 8 years a reversal of the trend of upward mobility for the partially trained. Instead, the opportunities for new careers in mental health have been offered to persons with an expressed interest in mental health programs, rather than to the demonstrated, proven interest in mental health by career nursing assistants. Nursing assistants are uniquely attuned to the recreational, creative, motoric, social, and dynamic needs of patients and are naturals for positions as recreational therapists, occupational therapy aides, community placement workers, day care program directors, etc.

Because this source of manpower

is too often bypassed, the government has invested millions of dollars developing programs to train the untrained to carry out the functions that are already being performed by mental health nursing assistants. A reevaluation of the entire manpower program is needed.

Recommendations

The following recommendations are offered as practical and practicable alternatives to some existing approaches.

Expanded educational programs—

School classes 6th–12th grades visit, not tour, mental hospitals.

Audiovisual techniques using video tapes of dialog between the mentally ill and school children where visits are not possible.

Closed circuit TV between school and hospital to aid dialog exchange between patient and student.

Public service time devoted to mental health material on commercial TV.

New research designs—

Special classes in the educational curriculum, the content of which will include materials on death and dying, anatomy, adult behavior problems and transitional difficulties, i.e., menopause, depression, security, economics, etc.

Determinations of levels of mental health in the mentally ill and correlation with habilitation and rehabilitation potential.

Questionnaire development by ethnocultural groups on mental health to define the limits of cultural tolerance for behavior deviation.

Research models for independent living arrangements managed by patients.

Pragmatic mental health programs—

School systems encouraged to develop program proposals in mental health.

Redefinition of the role of the community mental health center vis-a-vis conjoined role of clinical and community concept of prevention and treatment.

Use of 24-hour day-night hospital programs without regard for established diurnal social imperatives.

Therapeutic capacity for reinforcement, prevention, and treatment of mental health—

Evaluation of the relevancy of training programs in mental hospitals.

Evaluation of the communication credibility of administration and work force in the therapeutic treatment environment.

Establishment of treatment models adaptable to the compact environment of a ward setting or small unit with limited staff.

Manpower sharing in treatment programs involving the mental hospital and the community.

Efficient and effective manpower training and utilization—

Special training for selected hospital patients to serve as salaried attendants, maintenance, and kitchen helpers.

Upward mobility for nursing assistants first into specialized areas of recreational, occupational, and social service assistants rather than lateral movement of new recruits under special training program into these positions.

More programs designed to give minority professionals opportunities for administrative training.

Expansion of medical school and family-practice residency training programs to include extensive exposure to the problems of mental illness.

Administrative training for career senior nursing assistant staff in preparation for teaching and directorship positions.

Redefinition of professional and paraprofessional roles in treatment models.

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Communication in Community Decisions on the Problems of the Poor

James E. Grunig

The purpose of this study was to examine the communication contacts of public and private organizations and groups concerned with one problem of the poor—low- and moderate-income housing in a suburban community—and to determine the level of understanding achieved between these organizations, their clientele, and the general citizenry.

A Theory of Communication and Community Decision

Any local program or policy affecting the poor results from a community decision or a community nondecision. Communication as part of any decision process makes alternatives known and reduces uncertainty about the consequences of an alternative.

In community decisionmaking, a final decision or nondecision is usually traced to the power, influence, authority, or relative participation of the actors in a decision. Although communication is a necessary condition for the exertion of power, influence, or authority, it is not a sufficient condition.

Community decisions are derived from decision processes of constituent groups within the community. If any one group (such as the poor), however, is restricted from making a communication input, then it can exert little influence for its own interest. Thus, for this study it seems useful to study the communication and decision behaviors of governmental agencies and constituent groups within the community in order to determine the "overlap" which exists.

Decisionmaking model—There seem to be two primary dimensions in any decision situation: the recognition by the decisionmaker that a problem exists, and the extent and nature of the alternatives which are possible solutions to the problem. These two dimensions also predict the nature of any communication that might take place. Recognition of a problem is a condition for communication behavior—i.e., information seeking and giving. And information sought or given relates to alternatives perceived as feasible in the situation.

We can also predict the extent and nature of communication between two persons or groups of persons "cooriented" to a similar problematic situation—as they would be in a community setting. Groups or individuals would be expected to communicate most with one another when they feel that a problem exists, perceive it in roughly the same way, and recognize similar alternatives as feasible. Any combination with a group which perceives few alternatives as feasible would yield little communication—which would explain why the poor are seldom heard and less often understood. Any combination with a group which sees no problem in the status quo but recognizes competing alternatives would result in information giving but little seeking of information by that group.

By applying this model to the various organizations in a community, we should be able to explain the nature and direction of communication within a community. Secondly, we would predict that those segments of the public which communicate most with one another would have a more

accurate knowledge of each other's cognitions about alternatives to the problem.

In this study, we are especially interested in the relationships of various public and private groups to low-income groups and to middle-class suburban residents.

To determine these relationships, we used a coorientational model in which two types of cognitions can be measured: the perceptions of the *attributes* of alternatives and the *evaluations* of the alternatives. Each person is asked what his cognitions are and what he would predict the other's cognitions would be. From these responses, coorientational variables are determined: *congruency* on attributes and evaluations, *understanding* of the attributes and *agreement* on evaluations, and *accuracy*—how closely each can predict attributes and evaluations of the others.

We would predict that increased communication would lead first to increased accuracy, then possibly to more understanding of attributes. Increased congruency and agreement depend on many factors; communication is a necessary but not a sufficient condition for agreement and congruency.

Design of the Communication Study

Methodology—Montgomery County, Maryland, was chosen as a representative case-study community, and low-cost housing was chosen as the particular community problem to be studied.

Montgomery County is often called one of the richest counties in America, and it offers few single family houses which a family with less than $10,000 annual income can afford. Although the county is wealthy, poverty does exist largely in small enclaves of semi-rural housing which have been or are in the process of being surrounded by suburban expansion.

Montgomery County serves as an illustrative case study for several reasons. First, many believe that the suburbs must be integrated economically as well as racially if employment and housing problems of the poor are to be solved. Second, suburban institutions are generally believed to be unresponsive to the problems of the poor. Third, the county has many government agencies and citizen and business groups involved with the low-cost housing problem.

In carrying out the study, the author interviewed 26 representatives of county government agencies, business and Federal Government employers, middle-class volunteer organizations, black and/or low-income interest groups, real estate and housing interests, and reporters covering the county. All were responsible for communication programs and were familiar with the views and communication contacts of the organization. The sample exhausted most organizations concerned with housing in the county.

The interview was semistructured. Open-ended questions were used to measure the dimensions of the problem situation and also the coorientation variables. All responses to questions measuring problem definition and feasible alternatives to the problem were listed and then reduced through meaning analysis to four categories of problem definitions and five categories of feasible alternatives. Groups were placed into a typology with other groups whose respones were similar. These typologies were used as the primary unit of analysis.

Secondly, a sociometric procedure was used to determine the extent of information seeking and giving between groups. Each respondent was presented with a list of the 26 organi-

zations included in the study as well as citizen organizations in local neighborhoods which often support or oppose housing programs in their specific areas. He was then asked to check those to whom he had either given or received information about housing.

Next, a sociogram was constructed showing all information seeking and giving between the groups. Data in the sociogram were reduced to percentages to determine whether those perceiving the problem in the same way (within a typology) communicated more with one another than with those perceiving the problem in a different way (outside the typology).

The last phase of the analysis sought to determine the extent of coorientation of the members of the typologies with the poor and with middle-class suburban residents. Each respondent was asked what he thought would be the consequences of more low-income housing in the county, how he thought a poor person would answer the same question, and how a suburbanite would answer it. For the evaluative aspect of coorientation, respondents were asked what they thought should be done about the housing problem, how they thought both a poor person and a middle-class suburbanite would answer the question.

Cognitions of the poor and of middle-class residents were determined by asking respondents from organizations which had worked closely with the poor to reconstruct the poor's cognitions, and by analyzing newspaper reports of public hearings on housing projects to determine the suburbanites' cognition.

Results

Decision situation—Meaning analysis yielded four categories of problem definitions and six categories of alternative solutions to the problem:

Problem definitions
- Restrictions on builders
- Need for economic development
- No community interest in poor
- Need for better community

Possible alternatives (in order of decreasing difficulty)
- Public or low-cost housing for Washington poor
- Expansion of public housing in new and established areas
- Government restrictions and intervention
- Government incentives to builders
- Rehabilitation and continuation of present moderate programs
- No possible alternatives or alternate services

Two principal typologies of groups and agencies were developed—the "economic interests" and the "liberal interests." Within the liberal-interest typology there was also a subtype of four groups who differed somewhat in their perception of the problem and had frequent contact with the poor.

The economic interest group perceived the problem as a shortage of diversified housing needed for economic development of the county. The liberal-interest typology, however, perceived the problem in social terms—a lack of interest in the poor or a need for a better community.

On acceptance of alternative problem solutions, the economic typology believed solutions were feasible up to and including government incentives to builders. The liberal typology, however, believed government restrictions and intervention were also possible. The distinction is important: Most economic members are trying to prevent the latter alternative, most liberal members are actively promoting it. None of the groups interviewed believed the two most difficult alternatives were feasible.

The mass media studied recognized the problem in most of the four ways

discussed and did not fit into any of the typologies.

Communication contacts—The expected relationship was only partially confirmed. The liberal-interest typology did communicate more with those in the typology than those outside the typology. And the liberal group reported more contacts with itself than the economic group reported with the liberal group.

The economic-interest typology communicated as much with the liberal group as with itself, and it reported slightly fewer contacts with itself than the liberal group reported with it.

The four members of the liberal typology who had had a great deal of contact with the poor had more communication with members of the liberal typology than with those of the economic typology. Thus the poor are able to make communication input into the community-decision process through cooperating "liberal" groups and governmental departments, but they make little input through the "economic" typology.

All of the county government departments involved with housing communicate with citizen groups opposing low-income housing. In contrast, only three of the liberal group and one of the economic group report any contact with citizen associations supporting housing programs.

In short, opposing messages do enter the community-decision process in a formal manner. But perhaps more communication takes place informally when organization members interact daily with suburban friends and neighbors. Such contact seldom takes place with the poor.

The liberal typology reported substantially more press contact than the economic typology. Analysis of the liberal subtype shows that 63 percent of possible press contacts were made. Interviews with reporters, however, indicate that most coverage is of events, crises, sit-ins, and statements of organizational leaders, with little coverage of the problem as such.

Coorientation variables—For attributes of low-cost housing, the liberal typology's dominant self-responses were "improvements in the environment of the poor" and "improved social order." The economic typology's most frequent responses were "benefits for moderate-income employees" and "economic advantages for the county." Most liberals thought the poor would mention improvements in the environment as attributes of low-income housing. The majority of the economic typology could not predict what the poor would see as attributes of low-income housing.

The measure used to determine the cognitions of the poor shows that most of the poor do believe improved housing would lead to an improvement in their environment. But most are also extremely suspicious and fear that a housing program might hold many disadvantages for the poor.

Most liberals, then, do have some accuracy and share some common perceptions with the poor on the attributes of low-cost housing. But few liberals understand the suspicions, frustrations, and alienation which often make the poor believe that improved housing may in the long run have disadvantages for them. Those in the economic typology have little accuracy and understanding with the poor in relation to attributes of low-income housing.

Both typologies, however, coorient much better with suburbanites. Data based on newspaper reports of public hearings on housing projects show that most organizations in both typologies accurately predict the responses of opposition groups. But few mem-

bers of either typology perceive congruence with the opposition, and few share understanding of the attributes with these suburbanites.

For the evaluation aspect of coorientation, the most frequent liberal choice was "emphasis on governmental intervention and restrictions on land use" and "make maximum use of Federal programs." The economic typology, however, favored "giving incentives or subsidies to builders," "maximum use of government programs," and the "present moderate approach."

Most respondents in the liberal typology accurately predicted the evaluations of the poor, while nearly all in the economic typology replied "don't know" in predicting the poor's responses.

For suburban residents, both typologies accurately predicted responses, showing, for both groups, high accuracy but low perceived congruence and little agreement with opposing suburbanites.

Responses to the coorientation variables by the press, for both the poor and for suburbanites, were much the same as those of the liberals.

Results of the study support the principal predictions of the theory of communication and community decision discussed above. Individuals and groups seek or give information when they perceive a problem, and they generally communicate about those alternatives they perceive to be feasible in their situation. At the community level, groups communicate about community problems to other groups which perceive the problem in the same way and believe the same alternatives are possible. Finally, those groups that communicate most with one another understand one another better than they understand groups with which they have had little communication.

These findings help to illuminate the difficulty that "outside" groups, such as the poor, face in making input into the community-decision process. Most groups communicate about community problems with groups facing similar individual problems which require collective action to resolve. When middle-class groups dominate a community, few of them will ever have a functional need to communicate with the poor.

The study also illustrates the relationship of the poor to middle-class institutions. In this Washington suburb, both middle-class suburbanites and poor people make communication input in the decision process, but suburbanites appear to be best understood. Indeed, the poor generally have little conception of solutions to their problems. Thus both articulating the needs of the poor and organizing them to solve problems is extremely difficult.

Poverty-oriented organizations, however, face no such problem with middle-class people. Opposing suburban residents are usually part of the primary reference groups of individuals working in poverty organizations while the poor are not. Thus the opposition is more easily understood than the clientele, and, although unconsciously, the opposition is allowed more influence than the clientele when decisions are made.

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A Suggested School Mental Health Program

Richard S. Abrams, Michael Vanecko, and Irving Abrams

The need for psychiatric services in grade schools and high schools has grown faster than private medical psychiatric service and public clinic psychiatric service can possibly meet. The acuteness, extent, and frequency of problems among our population require unusual and massive programs to be effective. The existing mental health facilities are good as far as they can go, but the manpower shortage is massive, money is limited, and impractical approaches frequently are utilized in some of the facilities. Psychiatric service is only "scratching the surface" inside most large school systems. It therefore becomes indicated to employ and to train personnel for the unique needs of the "child in the classroom" and to deliver programs that are practical under existing conditions.

Different Needs Inside the School

The "child in school" is different from the "child at home." On entering school he meets formal competition with his peer group for the first time. He needs a fine balance between frustration, challenge, and satisfying accomplishments and experiences for proper growth and development. He must learn to respect restrictions, to obey, to play cooperatively, to speak clearly, to read, to spell, to write, to develop good health practices, and to perform more complicated tasks as he reaches toward maturity and toward a degree of independence.

The child who has the best chance has good heredity, a smooth prenatal experience, an uneventful natal day, and parents who set proper examples of total living. He needs good preschool years and good school years and at signs of educational failure or health failure, personnel should be available who can give "direction" to the child, the teacher, the parents, and others concerned. Large numbers of children do not have this, particularly among low-income groups. In one big city 48 percent of children entering the primary grade are already educationally retarded in terms of tests for their readiness and probable readiness to enter school. At the national level the proportion is 31 percent—also much too high!

Furthermore, many children who are not ready for school continue on a path of poor achievement and are promoted from grade to grade, not because they achieved, but because they are too big, too old, or the expense of holding back a child another year is too great.

This failure to achieve is more than just a trigger-mechanism in the development of emotional disturbances. The results of these educational failures are constantly with us in terms of school disorders, dropouts, runaways, sexual promiscuity, drug abuse, delinquency, crime, inability to get jobs, broken marriages later in life, and on and on.

Isolated, separated programs in the absence of massive total approaches help only a little. We are herein presenting a suggested Mental Health Program that we feel can help children, parents, and school personnel in a practical way. From our own experience with school personnel, it is our opinion that they welcome all help that will increase their knowledge of human behavior and that will help them to respond to classroom needs with more intelligence and specificity.

Since there is a lack of psychiatrists working in school systems, it becomes imperative that the few available apply the most practical procedures and programs to benefit in depth the greatest number of persons. The misapplication of procedures and programs is all too common.

The following multiple-faceted psychiatric program is based on practical experience because each phase has already been tried on a small scale and found to be practical. Also, the cost of the program is based on the most economical use of the professionals. Furthermore, multiples of the program can easily be applied so that the program can be small, medium, or large-scale, depending on the school system's needs and its ability to pay.

The Mental Health Program

Cost of the program—The only additional professional person the school system needs to employ is the psychiatrist. The working staff of teachers, psychologists, school nurses, social workers, etc., needed in the Mental Health Program are already employed in large school systems.

Employment of the psychiatrist—This is on a full-time basis.

Training of the psychiatrist in school affairs—The psychiatrist needs to visit schools, classrooms, classroom teachers, and special education personnel and facilities. He needs to go over the curricula at all grade levels to understand the philosophy and content. He needs to visit with other professionals who are giving service to the school children in order to have a good understanding of the child's school milieu and the thrust of the school system.

Appointment of a Group Behavior Committee—This consists of a group of five to seven school personnel appointed by the principal.

Training of the Group Behavior Committee—The psychiatrist gives a 2- to 4-months course to the members of the Group Behavior Committee. The content of the course and the management can vary with the ideas of the participants. However, the teachers must gain from this course a better understanding of the teacher's role, a better understanding of herself, of the normal child, of the nonachieving child, of the child "in trouble," of the child with a handicap, and so on.

Communication to other school personnel—The functions of the Committee and the part that other school personnel will have is to be explained clearly to all school personnel.

Functions of the Group Behavior Committee—Any teacher in the school can bring a "case" (a child with problems) to the attention of the Committee. A "child with problems" is known to the classroom teacher, the principal, to the school psychologist, and to the school nurse, and the workup of the child's case probably already embraced private medical or public medical facilities. Any child presented for psychologic or psychiatric appraisal and recommendations should have a prior or concurrent health examination and the findings made known to the Committee. The classroom teacher presents the case to the Committee and a discussion follows. The parent and child are in the waiting room to be called in as the Committee finds it indicated. The psychiatrist is the backup person, the resource person, and he is present during the entire discussion. Several conclusive decisions are possible for the child, the parents, and the school personnel:

- The committee may decide that the child can benefit by remaining in the same school facility but that

certain persons will coordinate efforts to find solutions for the child's problem. The professional staff must arrange a followup with private or public medical sources if the need is there, and make definite appointments and commitments for the child, parents, school personnel, and all those concerned with "rehabilitating" the child and family. Followup must not be the usual hit or miss, up-in-the-air type of thing, so that years later the long history of the child's problems becomes a longer history of the adults' problems! Repeat appointments need to be made with the Group Committee to review progress.

Any teacher in the school, who has no class during the time the Group Committee meets is invited to attend, listen, add constructive opinions, and learn. These Group Committee meetings are a great source of solving problems, of teaching school personnel, of helping children and parents in a more positive way. Of course, the matters discussed are confidential and teachers should be expected to act accordingly.

- The Committee may decide with the help of the psychiatrist that the child needs a residential teaching—psychiatric treatment facility and cannot be kept in the school where he is because he cannot benefit from staying any longer in the same school. If this is the decision, agreed to by the psychiatrist, assignments for followup must be made and progress reviewed until the child is placed.
- The Committee may decide the child needs to be in a classroom with a small class size, perhaps only six to ten pupils, a classroom that could be earmarked for emotionally disturbed children, so that he can have the benefit of a more personalized milieu.

Modifications of the functioning of the Group Behavior Committee—Obviously, the types of cases and problems presented to the Committee for discussion and action need not be limited to emotional "nonorganic" syndromes. Any child who has a condition in which there is educational retardation and school failure needs help. The parents of these types of children may also need help. A few selected members of a school staff, organized into a trained Committee, can be effective in structure of curricula or in modifying existing curricula to meet practical needs.

How far can you spread the services of the psychiatrist—The Group Behavior Committee meets once a week for 2 hours. The psychiatrist then can serve 10 Committees, one in the a.m. and one in the p.m., and thus he can serve 10 schools. However, he may wish to have a Committee meet twice a week in a large school or a "troubled" school, or he may wish to serve schools only 4 days a week and spend the 5th day of each week in other types of work.

The program presented here, in our opinion, is one of the best ways to serve a school system and use a limited amount of money in a practical way. If more schools need to be served, the cost can be multiplied accordingly.

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A Delivery System for Local Mental Health Services

Leonard T. Maholick

The lack of adequate manpower is a primary problem in mental health programing, and we must consider methods for constructing a model for local helping services in spite of the dismal outlook for a sizable net gain in our manpower resources. This paper is concerned with a system which requires the utilization of existing community helping resources and some dedicated mental health consultants.

The basic system consists of a four-phase operational structure allowing for an easy flow of patients from intake through followup. The public health nurse is the primary therapeutic agent who carries responsibility for her patients from the first contact to termination, thus providing continuity of care. The professional consultant sees individual patients with the nurse according to the needs of the case. The four phases of the system consist of the following: Intake (Phase I), Evaluation (Phase II), Counseling (Phase III), Followup (Phase IV).

Phase I: Intake—All referrals must come through a local physician who has examined the patient and completed a referral form for his patient to be seen at the Personal Problem Center. This procedure serves as an essential link among physician, patient, and counselor. During the Intake Phase the emphasis is placed on the following: What's your problem—Why are you here—How did you get here—What do you want from us—What problems, if any, do you wish to solve, and how willing are you to change. Additionally, eligibility for services is discussed. There is a definition of the services to be rendered, of the applicant's responsibility, and of the agency's responsibility. The individual may be accepted for continuing services, denied services, or referred elsewhere including immediate hospitalization or emergency care. If the decision is to continue, the applicant is given a Personal Data Kit (a Biographical Review and a Personal Problems Check List) and is instructed how to complete it, writing what he would like the counselor to know about him so that he might understand his needs faster and be of effective service. At the same time an appointment is given him for a joint consultation with the visiting psychiatrist and the nurse counselor at the earliest possible time.

Phase II: Evaluation—One hour is set aside for the troubled person to be seen jointly by the nurse and consulting psychiatrist. Initially 10 minutes are used by the nurse presenting her findings and observations according to a specially designed summary and planning guide. The psychiatrist plans his approach to the patient. This preconsultation conference is excellent for nurse and psychiatrist alike.

During the clinical review a search is made for primary clinical symptoms or complaints. Insofar as possible the precipitating problems leading to admission are further clarified. Reasons for coming to the Center and expectations are pursued with vigor. Observations and additional data permit the delineation of coping mechanisms, patterns of behavior, life style, or other significant data. On the basis of this clinical encounter a diagnosis is made and a treatment plan developed. As before, it is possible to provide service, discharge the individual,

refer him back to his community or refer him elsewhere. After the patient leaves, 5–10 minutes are spent discussing the case. If the individual is to continue with personal counseling, goals are defined, target areas are set up, and therapeutic tactics are delineated.

It is possible to demonstrate during the interview therapeutic methods and techniques in the presence of the patient, utilizing his positive assistance. The nurse and the patient may enter the interview situation however they wish. Nurse and consultant make tentative plans for a future joint consultation appointment with the patient to assess therapeutic progress or the lack of it.

Phase III Counseling:—The therapeutic approach in counseling emphasizes the strengths in the individual. The basic counseling philosophy assumes the presence of an inherent growth potential which, when activated, stimulates and challenges the individual to become a self-actualizing, responsible person. In the context of the therapeutic relationship the patient is confronted with his ineffectual life style and demands are made upon him to change and to assume total responsibility for himself as the full person he ought to be. Thus the person is taught openness and simple honesty. To assist him he is provided with a relationship he can utilize in developing his own potentials and growth as a person.

Several therapeutic goals are possible: symptomatic improvement, resolving the specific issues that led to the person's seeking assistance, or modification of coping mechanisms or patterns of behavior. Any one or a combination of the three can be used as the therapeutic objective. The ultimate goal is to develop his own potentials with meaning.

Generally, the troubled person is seen once a week by the nurse for 30–60 minutes, but may be seen more frequently depending on needs. As soon as it is practical and feasible, the individual is shifted into small group discussions. As a member of the group he is encouraged to participate in every way he can as well as to listen and to learn from others.

The consultant maintains a continuing contact and will see individual patients with the nurse depending on the needs of the patient and/or the nurse. These sessions generally cover a time interval of 30 minutes, divided as follows: 5 minutes preconsultation conference, 15–20 minutes direct clinical contact with the patient seen jointly; 5 minutes postclinical discussion; and 5 minutes dictation of progress notes. As before, each multiple conference is a learning opportunity for everyone as well as an intensely livening experience. Decisions are made about the need for continuing counseling, termination, and/or referral back to the community or elsewhere.

Phase IV: Followup—It may be necessary for some individuals to be seen occasionally over a long period of time. During these joint consultations, usually scheduled on a 20-minute basis, it is quite possible to check out symptoms, unresolved problems, coping mechanisms, and other significant data. Progress can be evaluated. Support and/or challenges can be instituted as appropriate.

However, there is a group for which long-term, perhaps lifelong, followup service is needed. There are the chronic psychotics, particularly the schizophrenics. As the Personal Problem Center continues to function successfully in the community it will gradually build up a case load of chronic psychotics. One way to han-

dle the increasing number is to have them come in small groups for a brief checkup with the nurse. Members of this particular population group may see the psychiatrist at increasingly longer intervals varying anywhere from 6–12 months, especially when the patient gives evidence of having achieved some semblance of controlled stability.

For this particular group, the use of mature, knowledgeable volunteers makes it possible to establish a day activity program one or more times a week. It is gratifying to see how this is accepted by the chronically ill. For some, it is the event of the week which is looked forward to and experienced with great relish. Vehicles for continuous communications between volunteers and staff must be planned into the total system. Preferably, before starting their work, volunteers should go through a prescribed orientation and training program.

Agency personnel must be given time to respond to the request for new work and responsibilities. If the response is predominantly positive, arrangements must be made to give the new counseling staff immediate exposure to psychiatric facilities. If a similar program is operational nearby, site visits can be not only anxiety-reducing and reassuring, but also stimulating and informative. Before more specific relevant training begins, a "big picture" should be presented to the entire staff for information and clarification.

Following this, provisions must be made for continuing Inservice Training. The entire system can fail for the lack of it. We have found it very useful to introduce the nurses to the whole concept of working with troubled people by first conducting a series of 10, 2–hours weekly training workshops. The workshops are standardized, goal-limited, utilize the case presentation method, and focus on the following: a point of view about human behavior and functioning which hopes to sensitize the trainees to the psychological and sociological dimensions of the individual; a standardized method for gathering comprehensive information about the individual; a systematic method of organizing, summarizing, and evaluating data so that problems and resources are identified for a direct and practical approach to planning for the use of existing skills in the community. In brief, our introductory training focuses on data collection, analysis, understanding, deciding, referral, and case management.

Following this course the nursing staff group should be provided with a controlled sensitivity training experience with mature, responsible, and skilled clinicians. Then the training is followed up with continuing teaching within the context of the therapeutic arena and is a never-ending process. Beyond that, special lectures-discussions are available on particular topics, depending on the interest and needs of the counselors and consultants.

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Peer Group Supervision

Rachel T. Hare and Susan T. Frankena

Peer-group supervision at the Philadelphia Child Guidance Clinic grew out of the experience of staff members who felt that consultation with colleagues on an informal basis and the free sharing of experience was often the most valuable help they received.

Two peer groups were formed, each with four members, both social workers and psychologists.

Each group developed a somewhat distinctive pattern. In Group A, members brought up problem cases, while Group B also required each therapist to review regularly some case selected at random by the other members from his caseload. Group B listened to members' audiotapes to achieve some balance between case-oriented and therapist-oriented supervision. Group A instituted discussions of more generic issues.

The groups concerned themselves with formulation of cases and treatment approaches. Ways were sought to understand various suggested approaches, and the aim of each group was to suggest an orientation that would allow the therapist to proceed on his own. At times, one member might be asked by another to join a case because of his particular skills, or the group might suggest outside consultation.

Group A found that the inclusion of a more experienced leader hampered openness and limited participation. Too little experience by one member also hindered the group because of diminished participation alternating with disproportionate requests for help.

The small size of each group allowed members to become acquainted with each other's work and lessened problems of defensiveness. Being case-oriented rather than therapist-oriented minimized criticism.

Group B found listening to tapes brought out more critical as well as defensive attitudes. This would have been less successful if the group had not developed a cohesiveness based on mutual respect and recognition of competence.

Much of the resistance to peer-group supervision in the clinic was expressed by students or by senior staff in a supervisory capacity. The question of whether peer-group supervision merely resulted in a sharing of ignorance was also raised. The diversity of professions and experience was felt to provide fresh opportunity for group members to learn what works for other therapists. As has been recognized, traditional supervision itself can be a way of sharing ignorance and even forcing it down.

The major disadvantage was the difficulty of administrative decision-making. It was felt that this could be handled by a core supervisor being exposed to the individual therapist's work at stated intervals by means of direct observations and case reviews.

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Nonhuman Primates and Psychoses

Harry F. Harlow and William T. McKinney, Jr.

The creation of animal models for any behavioral disorder involves the reproduction of the manifestations of the disorder by methods which bear a reasonable analogy to human causative factors. The contribution of monkey studies in understanding psychotic disorders occurring early in development has been the production of psychotic-like states in a controlled manner and the specification of variables which appear to be critical for the production of the syndromes. Another contribution has been the objective study of such syndromes on a longitudinal basis.

Obviously one should exercise caution in comparing abnormal behavior syndromes seen in nonhuman primates to those observed in human beings. The creation of experimental animal models for human behavioral disorders has come upon the scene as a distinct research area in recent years. Our social isolation research is older than this but its relevance to human psychopathology is being reconsidered as the whole area of experimental psychopathology matures. One problem with animal research has been the premature labeling of certain behavioral states in animals with human diagnostic terms without careful consideration of the etiology of the state or the meaning of the changes. To produce reasonable animal models requires the use of induction methods which bear some reasonable analogy to the etiologies of human disorders. It also requires careful description of the actual behavioral changes associated with different induction methods. The interpretation of the abnormal behaviors must also be made with due respect for species variation. Furthermore, treatment methods effective in reversing abnormal behavior in humans should be tried on nonhuman animals.

With awareness of these precautions, the use of experimental animal models has great potential. Thus far, it has been easiest to produce psychopathological states by social means only in young monkeys. We do not know whether any form of stress can be made severe enough to induce a psychotic-like state in older monkeys with normal social backgrounds. Such information would be relevant to human psychopathology.

Psychosis in the young human being almost certainly occurs as part of aberrant social development whether or not there are genetic and/or neurophysiological defects. The psychotic child has difficulty in forming attachments to other individuals be they parents or peers. In relation to this social problem the contribution of monkey studies has been the experimental documentation and description of the "affectional systems" or the stages of attachment that are important for the developing organism. Such data have broadened our perspective concerning developmental processes to include more than psychodynamic theories, though these two sets of data are not incompatible.

The affectional systems described in rhesus monkeys include: the infant-mother system; the mother-infant system; the peer system; the heterosexual system; and the paternal system. The sequence in which each system matures, as well as the normal behaviors characterizing each, had to be established before there could be understanding of the failure of any affectional system to develop or of its disruption once active.

Social Isolation

A syndrome in rhesus monkeys which may bear a close resemblance to human psychosis occurs as a result of total social isolation for the first 6 months of life. By total social isolation is meant the rearing of the infant from birth in an isolation chamber where he has no contact with either humans or other monkeys. When a young rhesus monkey is so reared, the result is a severely disturbed animal. Such animals, when they are removed from the chamber, spend most of their time huddled alone in a corner, rocking, self-clasping, and refusing to enter into play or other normal social encounters with their peers. They may self-aggress or engage in inappropriate and unpredictable aggression against, for example, a large dominant male. This is a behavior that no normal monkey in his "right mind" would ever attempt. The social withdrawal, the self-directed behaviors, and the sporadic and inappropriate expression of aggression are seen in psychotic children and in many psychotic adults.

Partial social isolation involves rearing young monkeys in bare wire cages without social contact with other monkeys. These animals also exhibit social withdrawal and other behavioral abnormalities. However, more of these deficits can be corrected with later social experience than is true following total isolation, and the deficits do not seem to be as severe.

Some of the critical variables producing the isolation syndrome can be specified. The more severe effects are produced when the social isolation is total, when it begins at birth, and when it lasts for at least 6 months. Alteration of these variables results in either no effect being produced or an attenuated one that is more easily reversed.

What is the human analog of rearing in social isolation? Total isolation comes closest to cases of drastic neglect of human infants probably not compatible with survival, though some cases of severe neglect are seen by pediatricians and child psychiatrists. A couple of additional comparisons might be justified. Children in marginal social groups may suffer from insufficient and inadequate social input, a situation of partial social isolation. Also the social input to infants and children in some families in all social classes may be variable in quality and consistency depending on familial interaction patterns.

The result in some young children is the development of infantile autism, other forms of childhood psychosis, or severe behavioral disorders. The behavioral similarities tween the isolate monkeys and autistic infants are striking. Both exhibit social withdrawal. The autistic child may be preoccupied with inanimate surroundings and intolerant of changes in these surroundings. The isolate monkeys also relate only to their physical environment, if at all, and try to shut out outside stimulation. Also, like some autistic infants, the isolate monkeys show self-aggressive behaviors including self-biting and self-mutilation. The interpretation of such behavioral similarities is a matter of conjecture and should be done cautiously.

The abnormal behavior states induced in young monkeys by social isolation are interesting in their own right, quite apart from their analogy to human pathological conditions. The isolation studies document the devastating and long-lasting effects of insufficient social input early in development and the specific areas in which behavioral deficits occur. While not necessarily supporting the critical

period hypothesis in its entirety, the data lend credence to the importance of very early experience with "significant others" in shaping and molding behavior. Monkeys are not humans and most of the time the reverse is true, yet each species shares with the other the necessity for loving and consistent social contact as it develops.

Another aspect of creating a monkey model is rehabilitation. Most efforts at rehabilitation of the total isolate monkeys have been unsuccessful. Only recently has the first successful rehabilitative study been completed at the Wisconsin Primate Laboratories. This was done by pairing isolate monkeys with "therapist monkeys" who were 3 months younger but at a developmental level similar to the regressed isolate monkeys. Equal age peers aggress against the isolates and provide a "counter-therapeutic" experience, but the younger monkeys touched the isolates gently and gradually initiated play and other social contacts in a nonthreatening manner. This method was successful and may provide support for the group treatment of some childhood psychotic states.

Anaclitic Depression

There are excellent monkey models for another form of childhood disturbance, namely depression. Indeed, monkey anaclitic depression may mirror human anaclitic depression more closely than any other monkey pathological state. In monkeys the syndrome is produced by separating a young infant from its mother. The reaction to separation on the part of the infant is a biphasic one characterized by an initial period of hyperactivity, cooing, and attempts to return to the object from which separated. This first "protest" stage lasts 24–36 hours after which there is a "despair" stage characterized by decreased activity, withdrawal to a corner, and huddling and rocking behaviors. Both stages are similar to those described in human infants and in older children. These studies also are providing a framework in which issues concerning separation phenomena can be better understood. Social bonds in young monkeys and humans are formed quickly and the effects of their disruption can be studied fruitfully in both humans and animals. The mother-infant bond is not the only attachment bond which, when broken, produces severe psychopathology. The bond in rhesus monkeys between young peers reared together is also strong, as evidenced by the effects of its disruption which in many ways are similar to those seen following mother-infant separation.

Research remains to be done in establishing animal models for human psychopathology and the criteria for documentation necessitates a comprehensive approach to include both social and biological dimensions. Animal models are available in many other medical specialties, and, despite the unique difficulties involved in creating such models in psychiatry, the data thus far would indicate the feasibility of continuing research efforts along these lines.

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The Contribution of Psychology in the Teaching of Psychiatry to Medical Students

David Shakow

There are several ways in which psychology contributes to humanization of the education of the future physician, and I consider psychiatry to be the most natural channel through which medical training can reestablish and extend the humanization process. As do most people nowadays, I view medical education as directed at providing society with persons not only competent in organic medicine, but also sensitive to human problems and prepared to deal with sick human beings rather than with organs or diseases.

Goals of Medical Education

There are four goals of medical education: training the student for competence in organic medicine, continuing development of the student as a human being, a generally oriented professionalization in his attitudes toward the practice of medicine, and a more specialized professional training in the psychological aspects of medicine.

In considering the four goals of medical education, I am not competent to say anything about specialized training in the technical aspects of the organic side of medicine.

As for the second goal, we may expect the majority of our students to continue to grow as decent human beings, especially since medical settings provide such unique behavior-supporting environments contributing to this end.

A third area involves making a humanistic physician of the medical student. Recent developments in medicine have tended to direct students' energies to areas deriving their prestige largely from laboratory work. The advances in neurophysiology, in molecular biology, and in other basic sciences, have tended to emphasize process rather than person, and this has resulted in a kind of impersonalization of the physician.

Foremost among the characteristics of the psychosocially oriented physician is the recognition of the importance of attitudes in interpersonal relationships, both the patient's and his own. Also integral to the humanization process is the need for identification with a "good profession," the need for development of ethical standards and feelings of responsibility in the student.

We now come to the last of the four goals: the preparation of the student for that other side of medicine, the social-behavioral side. Some 70 percent of patients have no demonstrable physical illness; ordinary medical training does not adequately prepare the physician to deal with this. The psychologist can contribute to better preparation through two kinds of specialized, professional training: a general type and a specific technical type. The general type is directed at laying some basic groundwork for the physician's effective action as a professional. The specific technical type is directed at providing him with theoretical and substantive knowledge about patients that will enable him to understand and evaluate their personality characteristics.

In the general area, the central issue is one which may best be subsumed under the rubric of "variability." Variability, both intra- and inter-

individual, is a profound problem in the behavioral sciences which involve the observation of human beings by other human beings. Medicine, both biological and social-psychological, depends on the process of observation to handle both kinds of variability. I distinguish four major types of observation: objective, participant, subjective, and of self.

Objective observation is directed toward carefully describing the impact on the individual of impinging internal and external forces that lead to his behaving the way he does. Such observations are those of a naturalist who is concerned with observing the patient's overt behavior.

Participant observation implies a distinctly more intimate relationship between the observer and the observed. In this situation both are interacting together, as in history-taking. The observer then has the difficult task of making objective observations and of determining in what ways his participation in the group process modifies the situation.

Subjective observation deals with the attempt to empathize with the patient, to try to understand how the patient feels about himself, his family, and his illness.

Self-observation is the student's understanding of his own feelings and attitudes. Here he asks himself why he behaves the way he does: why, for instance, he is so anxious with one patient and so calm with another. Such self-knowledge would seem to be vital for the practice of medicine, a field in which the physician is constantly faced with situations calling for sensitivity to the psychological and social aspects of others' illnesses, and in which it is so important to be aware of the dangers that lie in projecting one's own difficulties onto others.

Specific, technical, social-behavioral training consists primarily of introducing the student to psychological-social concepts through more systematically organized, formal courses. Most frequently, they would include courses on the nature and development of personality and on the use of psychological diagnostic devices for the study of the cognitive and affective functions of personality.

Implementation

The most important factor for developing general professional attitudes may lie in the nature of the teachers that we provide; they are the exemplars whom we set before students. Role models seem crucial, not only for the ethical principles that students adopt, but also for the humility that they develop in the face of the complex problems and for their freedom from too much orthodoxy.

Given the broadening of medical education into the social and behavioral sciences, the student is faced with many sources for emulation. With such a wide range of models to observe and work with, the student can perhaps more easily create for himself a composite model of a broadly based, humanized physician.

Before actually beginning to work extensively with diagnostic problems in patients, students should have a fairly intensive preliminary training period devoted to *naturalistic observation and report,* the factors on which diagnosis and therapy are so integrally based.

In *participant observation,* the difficulties of naturalistic observation are augmented, for the data that become available are limited by the capacity of the human observer as a reporting instrument. The participant-observation situation places even greater strictures on the reported data, since

one depends here upon a participant-observer whose participation is special, and likely to be extensive.

Subjective observation, with empathic insight into the nature of another person's difficulties and characteristics, is an essential part of the physician's armamentarium. The student must learn here to meet simultaneously the opposing demands of identification and objectivity called for by the practice of medicine. The student should, for these purposes, be provided with opportunities to participate in role-playing and psychodrama exercises.

An important aspect of the problem of the observer as an instrument relates to the degree to which one's own biases, affects, and problems color the material provided by the patient. It has long been obvious to those working in clinical psychiatry and in the behavioral sciences that self-evaluation is an essential prerequisite for their work. Medicine might very well adopt here the intensive, detailed case supervision that social work training has found is so effective in achieving at least some degree of self-knowledge. This permits an examination and working through of the student's own egocentric attitudes as revealed in his dealings with a particular patient.

Although as much of the teaching in technical psychology as possible should be carried out in the context of patients and field situations where observational techniques are emphasized, a considerable part will naturally have to be at a more formal and systematic level.

During the course of his training, the physician should develop, in his approach to professional problems, an apperceptive mass which has incorporated the following five principles basic to the understanding of personality: the genetic, the cryptic, the dynamic, the psychobiological, and the psychosocial. The course in personality should be devoted to the elaboration, development, and exemplification of these five principles. In the process, much attention would necessarily be paid to the relationships between pathology and normality. In the field work connected with such a course, there would be much opportunity to discuss concrete examples of personality expression, personal and social environments of the persons involved, and ethical issues.

The course on psychological diagnostic devices, while including some theoretical material about the nature of tests and measurements in psychology, should be devoted mainly to more practical aspects. It might include demonstrations of the tests, batteries of tests used during patient examinations, and "laboratory" work in the use of simpler devices.

In this ambitious program for training medical students, I have spelled out some of the implications of recommendations made by various medical and nonmedical educators in recent years. Medical education, like all other education, will have to envision broader goals in our increasingly complex world.

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mental health and the law

Criteria for Involuntary Hospitalization

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At the Psychiatric Division, Bellevue Hospital, New York City, lawyers from the Mental Health Information Service of the Supreme Court of the State of New York have been rendering free legal services to patients since the Mental Hygiene Law became operative in 1965. These lawyers not only counsel the patient on his rights, but also represent him if a hearing is held.

A patient admitted to Bellevue may be discharged, kept there for short-term treatment, or transferred to a State hospital either on a voluntary basis or involuntarily, that is, on a Two-Physician Certificate (Two-PC). When a Two-PC is signed by two staff psychiatrists, it is forwarded to the Certification Office of the hospital.

After certification, the patient is kept in Bellevue for another week so that he may contest the decision of the Bellevue psychiatrists through judicial review. If a court hearing is requested, the patient's name is placed on the hearing schedule compiled weekly at the Certification Office. The patient is then assigned to an attorney of the Mental Health Information Service (MHIS). These lawyers gather information and often confer with the psychiatrists. At this stage, some patients withdraw their request and agree to go to State hospitals either on a voluntary basis or on the Two-PC made earlier. Others may be discharged by psychiatrists.

At the weekly hearings MHIS lawyers present reports to the Court and represent the patient if he does not have a lawyer of his own. One of the two certifying psychiatrists usually testifies. The judge may make the final disposition in the case or adjourn it to a subsequent day.

Discharge Rates of Two Groups

The overall discharge rate among the hearing-request group has been in sharp contrast to the discharge rate among patients who were placed on Two-PC status but did not request a court hearing. The rate of out-of-court settlement has been increasing among patients requesting hearings, and a majority of such settlements have resulted in discharge of the patient by psychiatrists.

The nonrequest group is by far the larger, however. Approximately 12 percent of the patients on Two-PC status requested a court hearing in 1966 and 1967. The rate started to decrease and reached a low of 7 percent in 1969.

Discharge rates of both hearing-request and nonrequest groups have been rising, but the rate of the request group in 1969 is still significantly higher than that of the nonrequest group.

Sampling and Interview

Structured interviews for clinical and background information were conducted for 175 patients in the hearing-request sample and 325 patients in the nonrequest sample over a period of 10 months. The interview instrument consisted of Psychiatric Evaluation Form (PEF) for symptomatological assessment, and a

Structured Interview Schedule for background information.

In our study, the diagnosis noted from the Two-Physician Certificate and the PEF ratings by our interviewers were used to construct quantified scales of several clinical features. *Chronic Features or Mental Disorganization* were measured by combining three dimensions of speech disorganization, retardation-lack of emotion, and inappropriate affect, appearance, or behavior. *Paranoid Features* are described by a similar combination of hallucination, suspicion-persecution, and grandiosity. *Threat to Others* was indicated by agitation-excitement and belligerence-negativism. *Threat to Self* is represented by suicide-self-mutilation, a single scale on the PEF. The two latter scales were designed to measure "dangerousness" of the case. The number of previous mental hospitalizations was obtained to indicate possible duration of illness.

"Dangerousness" of the mentally ill—The question of dangerousness is generally inquired into in the hearing proceedings. There is a lack of agreement on a definition of dangerousness. Whereas some studies have relied upon "arrest" and "crime" as criteria for judging dangerousness, features daily observed in psychiatric practice also deserve careful consideration. Any overall definition of dangerousness must take into account features such as overt paranoid delusion or hallucination, agitation, belligerence, etc. We used quantitative measurements of the various clinical features and recent assaultive or suicidal histories to operationally define dangerousness.

Results

The clinical variables were compared for the hearing-request group and nonrequest group, separately for all diagnoses combined and for schizophrenics only. Diagnosis alone differentiated the two groups strongly: In the hearing-request group, schizophrenia, chronic undifferentiated type, was underrepresented and schizophrenia, paranoid type, was high. However, when symptomatology is quantified among schizophrenics, there is no essential difference between the two groups with respect to levels of paranoid features, although such difference is noted in regard to mental disorganization.

Patients with a higher score on Threat to Self tend to remain in the nonrequest group. Threat to Self shows practically no difference between hospitalized and discharged patients in the nonrequest group, but it does differentiate hospitalization and discharge within the hearing-request group, regardless of whether the decision to hospitalize or discharge is made by psychiatrists or judges.

Statistical differences between scores on Threat to Self for hearing-request discharged (by both psychiatrists and judges) and for nonrequest discharged were highly significant, whereas within the nonrequest group, the differences between proportions discharged and hospitalized were not significant. In other words, suicidal thought alone does not influence ultimate disposition for the nonrequest group. Once such a patient requests a hearing, however, suicidal thinking weighs heavily against his discharge. For psychiatrists, this indicates that the criteria of hospitalization changes once a patient requests a hearing; for judges, it indicates that Threat to Self sways them toward hospitalization. However, judges are generally conservative in their rulings. Cases discharged by judges show the lowest scores in

each of the four clinical scales among all subgroups by disposition, including hospitalization. These symptomatologically less severe patients failed to be discharged by psychiatrists and eventually reached the courtroom.

Chronic features or mental disorganization seem to make a difference to eventual disposition, regardless of whether the patient requested a hearing or not, but this is particularly true in the case of those who requested a hearing. Mentally disorganized patients are being hospitalized by both psychiatrists and judges.

The percentage of patients discharged in hearing request and that of nonrequest groups was compared for other clinical variables. Here, differences were significant in all categories except "other types of schizophrenia," "actual or threatened violence," and "attempted or threatened suicide." Now the statistical *insignificance* of the two categories associated with violent or suicidal behavior becomes meaningful. Schizophrenics admitted following violent or suicidal episodes or threats have much less chance of being discharged than schizophrenics with other histories, even if they request a hearing.

When history does not reveal "dangerousness," patients are quite readily discharged from Bellevue when they request a hearing. "Dangerousness" and severe mental disorganization receive high priority among criteria of hospitalization, and need for psychiatric treatment appears to be of secondary importance.

Before the present Mental Hygiene Law became operative, the majority of patients requesting hearings was presented to the court. For example, in 1964, exactly 300 more cases were resolved in the courtroom at Bellevue than in 1966, and an overwhelming majority of them was committed. As late as 1969, 75 percent of the judicial rulings were for hospitalization. Therefore, it would appear reasonable to assume that many patients discharged by psychiatrists would have been hospitalized by judges if presented to the court. Thus, an ultimate decision of Bellevue psychiatrists not to present the case and to discharge the patient instead may be jeopardizing his chance to be hospitalized.

Not only psychiatrists, but also lawyers, make an effort to settle the case outside the courtroom; lawyers know that their client's chance of getting discharged is better outside the court than inside. Even though these discharged patients may have lost their chance to receive "treatment," the essential question still remains unanswered; that is, how substantial such therapeutic benefit would have been. For some, ideologically, no therapy would be worthwhile if the patient were forced into it. Others may feel that resulting substantial benefit may justify the means, that is, involuntary hospitalization.

The trend in psychiatry is to appraise the therapeutic aspects of hospitalization and to shorten or avoid it. The results may be regrettable or may be beneficial; in either case, they cry out for impartial assessment—such as would be provided by a retrospective analysis of discharged cases in comparison with hospitalized ones.

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mental health news digests

Mental Health Progress in Appalachia

In 1964 a group met to consider mental health programs and problems in Appalachia. The conclusion was that "there are neither enough services available nor trained people to administer them."

Much of Appalachia is rural. When Federal funds became available for construction and staffing of community mental health centers, rural counties though eligible for such funds had little prior experience with mental health services except those in often-distant State mental hospitals. They were unfamiliar with the benefits that might be expected from a mental health center near people's homes. And, having a low tax base, many rural counties were unable to provide matching funds. Many thought that the prospect of having community mental health centers in rural areas was an unlikely prospect, and rural counties in Appalachia seemed to be no exception.

There are many definitions of "rural." One definition is that a rural county is one in which more than half of the people live in communities of 2,500 or less. Eighty-two percent of the counties in Appalachia are rural, using this definition.

But the expectations were wrong. Appalachia now has 167, or 52 percent, of its rural counties in the service area of community mental health centers. In spite of all its problems and poverty, Appalachia has exceeded the national average in bringing health services to its people.

In all, 49 community mental health centers have received grants to serve one or more rural counties in Appalachia. Twenty centers have only construction grants, 10 only staffing grants, and 19 have both construction and staffing grants.

It must be remembered, of course, that Appalachia is not an "island," and many of the rural counties are grouped with counties outside Appalachia. Therefore, not all centers are located within Appalachia itself. Yet, 40 of the 49 community mental health centers are within the area served by the Appalachian Commission, and 25 of them are in rural counties of Appalachia. It is likely that economic as well as mental health benefits will ensue as these centers become operations. About two-thirds of the rural counties in Appalachia are eligible for preferential funding as poverty counties. More than half are not now receiving this benefit. (Adapted from a paper by Dorothea L. Dolan, Special Assistant for Rural Mental Health, Division of Mental Health Service Programs, NIMH.)

Center for Policy Research

The Center for Policy Research is intended to provide facilities for and an intellectual environment conducive to research leading to the formulation and reformulation of public policy, especially with regard to social domestic issues. One of its main goals is to conduct evaluative studies of existing and planned programs, with the special purpose of feeding back the findings to various policy areas. During the past few months the Center has done research on communication, health, and community control.

In the area of communication, work has begun on a study titled "A Participatory Technology System—For Multiple Interactive Exchanges and Expression of Ideas, Attitudes, and Choices,"—or MINERVA. The study will deal with the technological features and social rules that would allow cable television to be used as a mass participatory technology—one in which a large number of citizens would be able to discuss public issues. Another possible use of cable television is in personal relations. In a study of "Methods to Promote Growth in Marital Relationships," the degree to which learning processes can be helped by cable TV programs will be assessed. A program dealing with marriage-related problems will be broadcast, and couples will discuss the issues raised, either between themselves or with other couples. The effect of socioeconomic status and the presence or absence of lateral communication are the main variables to be studied.

One of the studies in the area of health care deals with "Private Practitioners and Community Mental Health Centers," especially the problem of obtaining sufficient professional practitioners. Two surveys will be conducted. In one, directors of community mental health centers will be interviewed by telephone, and in the other questionnaires will be sent to psychiatrists participating in the centers and to psychiatrists who are not participating.

Two new studies on community control are underway. The past decade has been characterized by the rapid formation of new interest groups and the awareness of new issues, but little research has been done on these processes. In a study of the "Dynamics of Short-Run Social Change," stories in the New York Times Annual Index from 1950 to 1969 will be coded. Among the hypotheses to be tested are whether or not the number of groups has increased, whether they are issue-specific, and how long after the formation of groups there is a substantial change in public opinion. The bases of responsiveness to new groups also will be examined. Another project is on "Community Crime Control: an Exploratory Study." Up to now, most voluntary crime control programs have tended to be short-lived and to use socially marginal or illegitimate means to achieve their goals. This study will attempt to identify the factors which will account for greater stability and responsibility among crime control groups in the community. (Adapted from Newsletter #7 of the Center for Policy Research, Inc., 475 Riverside Drive, New York, N.Y. 10027.)

NIMH Research Task Force

The NIMH has recently launched a year-long study of all its research activities. Since 1948 the Institute has supported and conducted over 7,000 research projects at a cost of over one billion dollars. The rapid growth of its research programs, especially during the 1960's, has been accompanied by a broad diversification not only of research subject matter and techniques, but of administrative and organizational support mechanisms. It was therefore considered appropriate and necessary to assess the impact of the NIMH's research efforts to date, to identify priority areas for the years ahead, and to develop optimal administrative and organizational arrangements designed to strengthen the research arm of the Institute.

The work of the Task Force is being conducted through 10 Study Groups,

each devoted to the analysis, evaluation, and planning of a given area of research activity. The areas are: biological and physiological processes, psychological processes, social and cultural processes, mental illness and behavior disorders, drug abuse, alcoholism, social problems, treatment techniques, mental health services, and research information and utilization. NIMH staff as well as individuals outside the NIMH are serving on the Study Groups. The study is expected to be completed in the early summer of 1973.

Standards for Psychological Service Facilities

The American Psychological Association has begun a 2–year study, funded by the NIMH, to research and develop a set of standards for psychological services. The study will assess in depth current programs of psychological services in health facilities with the goal of developing improved and more uniform standards for the delivery of high quality services. The result will be a publication of standards to be used as a guide by health providers, trainers, administrators, legislators, consumers, and members of other professions. (From the *APA Monitor,* June 1972)

Mental Health Services for American Indians and Alaskan Natives

There are 31 community mental health centers in areas of the United States serving American Indians and Alaskan Natives: five in Arizona, four each in Montana and North Dakota, three each in Idaho and Washington, two each in Alaska, California, and Minnesota, and one each in Maine, New Mexico, North Carolina, South Dakota, Utah, and Wisconsin. For a pamphlet listing the addresses of these centers, write to Public Inquiries, National Institute of Mental Health, 5600 Fishers Lane, Room 15C17, Rockville, Md. 20852.

Conferences

A 3-day conference on "Sex, Marriage, and the Family: Whence and Whither?" will be held in Montreal on October 30–November 1, 1972. Areas to be covered include family and sexual behavior among animals and the effects upon these of social pressures; the variety of family patterns in other cultures and their ecological determinants; changing patterns in the western world including attitudes toward abortion, patterns of sexual protest, group marriage, changing sex roles, and sex in mass media. For information write to the Conference Committee, The Mental Hygiene Institute, Inc., 3690 Peel St., Montreal 112, Canada.

The Fifth International Conference of the World Union of Organizations for the Safeguard of Youth, which will feature the theme "Free Time and Freedom," will be held on December 4–8, 1972 at the UNESCO House in Paris. For information and a preliminary program write to the Secretary General of the World Union at 28, place Saint-Georges, 75–Paris 9e, France.